WHEN DEATH DO US PART:

NURSES ON POST-MORTEM CARE

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ABSTRACT

When Death Do Us Part: Nurses on Post-Mortem Care

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The present study was undertaken to describe nurses' post-mortem care experiences and to determine the influence it exerts on their attitudes toward death; secondly, to relate variations in attitudes toward death to the type of hospital setting in which the nurses work, and to the nurses' cultural backgrounds; and finally, to offer certain recommendations.

This quantitative and qualitative study was conducted in three separate hospital settings: a palliative care unit, a medical unit and a neurosurgery unit. The palliative care and the medical units were located in Canada, while the neurosurgery unit was located in Israel. Using a self administered, 49-item questionnaire, data was collected from 32 nurses (nine palliative care nurses, eight medical nurses, and 15 Israeli nurses). Seven nurses were interviewed on the topic in depth.

Nurses' experiences with post-mortem care and death were diverse and represented a confluence of factors. Nurses' personalities, religious beliefs, cultural value systems, customs, life experiences, and the unit's orientation all converged and influenced their attitudes toward death. Culture and the unit's orientation exerted the strongest influence on nurses' attitudes. Exposure to dying was the most influential factor in determining attitudes toward death and dying, with palliative care nurses being most comfortable in

dealing with death. Cultural differences also emerged, with Canadian and Israeli nurses entertaining divergent attitudes toward death, spirituality and post-mortem care. Death was conceptualised by some nurses as the end of an organism, and by others as the beginning of another form of existence. Post-mortem care was reported as an emotionally demanding task, yet most Canadian nurses considered the experience rewarding. The wrapping of the body in a plastic shroud and the covering of the face was the aspect nurses disliked the most; they felt it was repugnant, dehumanising and disrespectful.

Several recommendations are offered for training, education, further research and for resource allocation.

To my beloved mother, Berta Iacob Covrigaru,

who taught me about unconditional love,

and

To all those who granted me the privilege of accompanying them on their journey through the Valley of the Shadow of Death, who have taught me about suffering, courage, dignity, and the capacity of the human spirit to soar and transcend.

Forever in my heart.

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Death is a dialogue between

The spirit and the dust.

Emily Dickinson (1993:162)

Each culture is the sum of rules with which the individual could come to terms with pain, sickness and death - could interpret them and practise compassion amongst others faced by the same threats. Each culture sets the myths, the rituals, the taboos and the ethical standards needed to deal with the fragility of life - to explain the reason for pain, the dignity of the sick, and the role of the dying and death.

Ivan Illich (1979:919)

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CHAPTER I

INTRODUCTION

Our society has been portrayed by social scientists, as a death-denying society. In the past century, death became invisible and unmentionable. It replaced sex as a social taboo, banned from polite conversation or social discourse. Death has been secularised, deritualised and medicalised. It is no longer a sacred encounter between the individual and God. Religious eschatology was replaced by medical conceptualisations. Death was removed from the realm of religious concern into the realm of scientific investigation.

Changes in demographics, mortality and morbidity patterns and urbanisation have all contributed to a change in the dying milieu. With the change in locale, death was expelled from common individual experience. Our concept of death was altered. The finitude of the self became a terrifying prospect. However, death is an everlasting reality to the dying and the health care personnel responsible for their care.

Nurses, traditionally, cared for sick and dying patients in their homes or in the hospitals. Review of nursing literature from the turn of the century illustrates the distinctive characteristics of nursing care provided to terminally ill patients and their families. Nursing care encompassed both physical care and emotional support for the dying and their family members, as well as post-mortem care after the death occurred.

Past and present nursing textbooks and literature indicate that procedures and rationale of post-mortem care have changed little over the past century. Nursing students

today, as in the past, are taught the procedures and rationale of post-mortem care during fundamental nursing courses.

Despite the proliferation of literature and research about dying and death, nurses' experiences and reactions to their patients' death and post-mortem care remain, however, largely undisclosed, seldom discussed and understudied. The literature describing nurses' experiences giving post-mortem care and response to a patient's death is scant. Consequently, little is known of nurses' feelings, reactions, and attitudes to the myriad duties termed post-mortem care and the sources of support utilised to deal with these deaths.

By virtue of their work, nurses should not be strangers to death, however, because of the increased tendency to divide nursing into distinct specialities, some nurses become more attuned to death than others. Encounters with death leave lasting impressions, yet the significance of these encounters in socialising the nurse have not been recognised, nor were they studied.

The purpose of the study was threefold: to describe nurses' post-mortem care experiences and determine the influence it exerts on their attitudes toward death; to relate variation in attitudes toward death to the type of hospital setting in which the nurses work and to the nurses' culture background; to examine the sources of support nurses utilised to cope with the emotional distress caused by their exposure to death.

After reviewing nursing literature, it is reasonable to assume that the type of hospital setting in which nurses work would have an influence on their attitudes. The works of Glaser and Strauss (1965), Folta (1965), Golub and Reznikoff (1971) reported

that nurses in different hospital units had different anxiety levels when exposed to death and the dying. While anxiety was not included in this study as a independent variable, the possibility that anxiety would be an intervening variable affecting attitudes was recognised.

Thompson (1985) reported that work setting was a more significant force in shaping attitudes than experience. Caring for dying patients in the palliative care unit does not arouse the same response in the nursing staff, as does caring for the dying in units with curative orientation. Palliative care nurses were found to approach their work with greater ease.

Whereas earlier studies looked at differences in attitudes of nurses working in different hospital units within a Western culture, this study examines the differences in attitudes of nurses working in remarkably different settings. The study compares and contrasts attitudes of nurses in three hospital units: palliative, medical and neurosurgery units in two different cultures: Canadian and Israeli.

The significance of the study lies in the investigation of nurses' recollections of patients' deaths and post-mortem care experiences and the salient influence they exert in shaping attitudes toward death. Second, by describing nurses' experiences with post-mortem care, tasks seldom discussed or witnessed, the difficulties it engenders will be illuminated, and ultimately contribute to the strengthening of nursing practices.

General Organisation

Chapter II is an analysis and review of Western attitudes toward death and from Antiquity and the "tame death" to the "invisible death" of contemporary North American society. It also explores funerary rites and their evolution.

Chapter III describes the methodology used in this qualitative and quantitative research and reports the sample characteristics, the study's limitations and the Palliative Care Unit.

Chapter IV is devoted to the analyses of nurses' personal recollections and experiences in providing post-mortem care. It also explores nurse' reactions to specific aspects of post-mortem care and the emotions they engender.

Chapter V examines nurses responses regarding the subjective meaning of death, influences on attitudes and beliefs, and personal views on spirituality.

Chapter VI provides the conclusions drawn from the study and implications for nursing practices, education and training, allocation of resources and further research.

CHAPTER II

THE "TAME DEATH" TO THE "INVISIBLE DEATH"

Death is biologically inevitable and thus universal. Yet attitudes towards death are not instinctive. Each society, through its belief system, secular and religious rituals, constructs the meaning of death for its members. The fundamental achievement of any culture is its ability to provide a symbolic system that offers meaning to the temporal nature of human existence concomitant with cultural values by which individual members can function and assess their experiences vis-à-vis the everlasting reality of death.

To comprehend a culture's conception of the nature and meaning of death, a thorough examination history of attitudes, beliefs about death, and the emblematic characteristics ascribed to the corpse are imperative. In most cultures, and throughout history, the human body served to symbolise moral and social truths. Invariably, the body, after death, continues to maintain and command symbolic representation.

Every society is confronted with the predicament of how to dispose of its dead. Funerals as rituals of disposition have been observed in most societies. The funeral, as a ceremony associated with the act of disposing of the dead, has existed since earliest recorded history. However, death was, and still is, a social event. It is one of the most important social occasions in the cycle of life. Funeral rituals serve universally the important function of public acknowledgement that a death has occurred, provide a

framework to support those most affected by the death, and allow a ritualistic disposal of the human remains.

From epoch to epoch, from culture to culture, the evolution of death rituals and customs has proceeded along unique, yet analogous, paths. The existing differences in rituals are not exclusively related to variation among cultures and societies but rather attributed to differences in practices within a particular society. The divergence in death rituals stems from a variety of factors, such as the age of the deceased, the deceased's social status and, most importantly in antediluvian societies, the manner of death. Moreover the actual method of disposition, whether the body is cremated, inhumed or disposed in any other way, imposes variation of funeral rituals.

Anthropological comparative literature established through the classification of rituals and practices, the existence of eight mutually shared dominant concepts that have subsequently influenced the historical origins of contemporary practices. These cardinal concepts include: the notion of the corpse as a pollutant or taboo; institutionalised mourning; the incessant life of the dead; communion of the dead in the funeral feast; offerings on behalf of the dead and attempts to amend for their sins; death witchcraft; shielding the dead from fiends; and, last but not least, the fear of ghosts; thus the fear of the dead (Benton, 1978:154). This fear of death is evident both in medieval Christianity and the Old Testament.

The Old Testament alludes to the corpse as defiled. In Leviticus, Chapter 21; Verse 11, the high priest is instructed that "he must not go near a dead's man corpse, he must not make himself unclean even for his father or mother" (The Jerusalem Bible, 1968).

Similarly, the ancient Persians constructed, far from human habitation, the dakmas - the towers of silence, into which corpses were thrown for birds of prey and dogs to feast on the unclean flesh (Benton, 1978:155).

The extent to which the corpse is feared and the aversion expressed to its presence vary widely from one culture to the next. The fear appears, at first, to be attributed to humans innate repulsion to the natural process of decomposition. Yet, this explanation seems one-dimensional when considering the extent of to which the fear influences the manner, swiftness and the attention (or lack of it) accorded to the corpse.

Hertz asserted that the corpse was feared for numerous reasons. The "gradual elimination of the social person of the deceased and the effects that it has on the status and self conception of the living" (Huntington and Metcalf, 1979:65) is one explanation. The perseverance of the soul or "spiritual essence" after death and its potential threat to the living during the liminal phase represents an additional source of fear.

The next section will review some of the themes and variations in attitudes toward death, the dead and funerary practices as they evolved from the "tame death" of antiquity to the "invisible death" of present day.

"The Tame Death"

Phillipe Ariès in his monumental work The Hour of our Death, (1981) provided an overview of European attitudes toward death. During the millennium preceding the Middle Ages, attitude toward death remained unchanged. The traditional attitude was one of resignation and acceptance. Death and life were considered to exist simultaneously.

"Death, close and familiar, yet diminished and desensitised" (1981:28). Ariès refers to the familiar death as the "tame death" and states that "It is the oldest death there is" (1981:28).

Death had a public aspect - the dying individual was the focus of the social group that gathered around the deathbed. Since continuity of life was attained through kinship, clan or tribe, the individual destiny was not of cardinal importance or significance. The individual was primarily a social constituent who acted according to the prescripts of custom. Thus their importance was only vis-à-vis their obligation to the group "death was not a personal drama but an ordeal for the community, which was responsible for the continuity of the race" (Ariès, 1981:603). Ritualization of death was one element in the scheme of man against nature. In order to contain its effects, death was confined in ceremony and transformed into a public panoply. Although death was tamed and ritualised it was not experienced as a neutral phenomenon. It was always regarded as a misfortune.

The perceived dualistic nature of the body and the superiority of the soul influenced conceptions of life and death and the nature of the hereafter. "The body was regarded as the tomb of the soul" (Synnott, 1993:9). To Socrates and Plato, the body and soul were two separate entities, with the soul as the "helpless prisoner" of the body. The body was perceived as inherently evil and only in death was the soul liberated from the body. Death was perceived as sleep. Stoic philosophers regarded the body as "poor ass, clay, corruption and corpse" (Synnott, 1993:10-11). Death was a release from physical constraints. Among early Christians the dualism of the body and soul was widely

assumed. There was a distinction between the physical and spiritual components of the body. The body was a temple of the Holy Spirit and part of Christ. It was both mortal and immortal - physical at death and spiritual at resurrection (Synnott, 1993:12-13).

Antiquity marks the rise of an acute consciousness of human mortality - a consciousness that persevered through the ages and is no less acute in contemporary society. During the early Middle Ages, doubts about the myths and reigning religious dogma increased. Death was a reason for perturbation. Death was regarded as evil and fearful, a great misfortune that engendered various emotions and attitudes (Lattimer, 1962). Death was not only fearsome but inevitable: an inescapable fate. Only the emergence of divergent views of immortality of the soul offered some solace. The belief in the immortality of the soul offered plausible hope for immortality: hope but not certitude as was believed in previous eras. Beliefs in the immortality of the soul stemmed from the soul's incorporeality: that which is considered metaphysical cannot cease to exist. The belief in the immortality of the soul among early Christians influenced and modified funeral customs. "The Mass, the Celebration of Passion, Death and the Resurrection of Christ, became an integral part of the final rites" (Benton, 1978:164).

Afterlife was a period characterised by peace and rest while awaiting the true end of life - resurrection and the life in the world to come. However, the dormant state was dependent on individual piety, the laws of nature or the behaviour of survivors (Ariès, 1981:29).

In spite of familiarity with death, the dead were feared. Their burial places were kept out of harm's way. The veneration shown to tombs in the "tame death" epoch

stemmed from fear - fear of the return of the dead. The dead were seen as impure, polluted and they represented a danger to the living.

Funeral Rites

Early Christian and contemporary funeral practices evolved from pagan ceremonies and beliefs. The custom of lighting candles around the deceased, and watching at its side all night (a custom still practised by Jews) originated with the belief that the corpse, similarly to the sleeping individual, was especially susceptible to attacks of demons. Similarly, the custom of tolling a bell when an individual died was intended to startle and scare the evil spirits that might attack the soul of the deceased. For similar reasons, in the Catholic ritual, the Holy Eucharist was often placed in the grave (Benton, 1978:162).

The funeral was characterised by its simplicity. The eyes of the deceased were closed, the body was anointed and wrapped in a linen sheet with spices (Benton, 1978: 162). A wake, or a period of watching over the corpse, to be assured that death had indeed occurred, preceded the Mass and eventual internment. The burial was mostly in catacombs, where loculi, shelflike graves, were dug into the clay walls of a subterranean tunnel. The individual graves were covered with tablets or slates inscribed with the deceased's name, and age, and, at times, a blessing (Benton, 1978:163).

These beliefs prevailed as late as 563 A.D. In a decree issued by the Council of Braga, the burial of holy martyrs in the basilica was strictly prohibited. The decree stated that basilicas could not be extended privileges that contradicted the practices of burial observed by the towns. The transformation in attitude, from the abhorrence of the dead to

coexistence with the dead within the city walls, was due to the profound differences between old pagan beliefs that influenced early Christian attitude toward the dead and the new faith in the resurrection of the body. This was incorporated with the worship of ancient martyrs and their tombs (Ariès, 1981:35).

Some early Christians believed that pagan worship of the tombs was antithetical to the dogma of resurrection of the body. Saint Ignatius of Antioch expressed his hope that animals of prey devour his body (Ariès, 1981:31). The Anchorite monks and their descendants, the Eastern monks in the Egyptian desert, declared their utter disregard for their mortal remains. However, the ascetic disregard for the body, living or dead, proclaimed by members of different monasteries and religious sects, did not prevail among the Christian populace for whom the new-found faith in resurrection was integrated with the traditional tomb worship. "But this reconciliation did not serve to reinforce the ancient fear of the dead; on the contrary, it led to familiarity that eventually, in the 18th century, bordered on indifference" (Ariès, 1981:31).

The fear of the dead was replaced by the fear of not rising from the dead. Resurrection on the Day of Judgement, it was believed, was contingent upon receiving a proper burial and having an unviolated grave (Ariès, 1981:32). Christianity's adaptation of the Ancient cult of martyrs was founded on the supposition of the sanctity of the dead.

Ecclesiastical writers' efforts to persuade the populace of God's omnipotence with regard to restoring and recreating violated bodies were ineffective. The populace "had a very vivid sense of the unity and the continuity of the individual and did not distinguish the soul from the body or the glorified body from the fleshy one" (Ariès, 1981:32). The

abysmal fear of violation of the body and, thus, denial of resurrection and eternal life, contributed to the prevalent custom of burial near the tombs of the martyrs. The martyrs were considered the only ones among the saints who could provide protection from desecration of the physical and spiritual purity on the Day of Judgement (Ariès, 1981:32-33).

The worshipped sites of their tombs drew other tombs . The desire to be buried ad sanctos is stated by Maximus of Turin, a 5th century author:

> The martyrs will keep guard over us, who live with our bodies, and they will take us into their care when we have forsaken our bodies. Here they'll prevent us from falling into sinful ways, there they will protect us from the horrors of hell." (Ariès, 1974:16).

By 752, St. Cuthbert acquired the authorisation of the Pope to establish the churchyard as "suitable for the burial of the dead" (Puckle, 1926:140) and once again the dead were buried within the city. The separation that existed between the Church and its cemetery became obscured. The dead, who coexisted with the inhabitants of the suburban neighbourhoods around the abbeys, were once again buried within the walls of the cities from which they had been excluded for a millennium (Ariès, 1974:18). Beliefs in the existence of supernatural powers and the necessity to restrain the evil spirits was conducive to the inception of the practice of interment of the dead under church floors. Although this practice of inhumation was proscribed by the Code of Justinian (about 550 A.D.) it continued (Benton, 1978:156).

Given the collectivist orientation of the period, what was imperative was not the giving of an identified home to each body, but rather that one remained as close to a saint as possible. As late as the 17th century, the exact location of ones' bones was of no consequence, provided they remained near the saints or in the church, close to the altar (Ariès, 1974:22). The body was entrusted to the church to do with it as it saw fit, provided that they remained within its holy environs. Between the 10th and 12th centuries, the church and the courtyard became public places.

During the 11th and 12th centuries, a new Christian view emerged. Victory over death became less certain and vision of eternal torture gained prominence. Death was approached with less confidence, and also with fear. The cemetery became a place of refuge within the walls of the church. Houses were built, shops appeared, business was conducted beside the charnel houses. The cemetery became a crowded and busy place. Subsequently, the Church Council of Rouen, in 1231, outlawed dancing in cemeteries and churches and used excommunication as a deterrent In 1405, another Council banned dancing, gambling, jugglers, musicians, theatrical companies, and charlatans from the cemeteries.

"Death of the Self"

The Christian view of death was gradually transformed. Although the belief in a common destiny held by early Christians prevailed during the early Middle Ages, there was a growing concern for the destiny of the individual. The traditional relationship between self and others was altered. The concern over "one's own identity prevailed over

the submission to the collective destiny" (Ariès, 1981:605). Social relationships were transformed. Individuals ceased to regard themselves as part of the community bound to a collective destiny and the final judgement at the end of the world. Subsequently, individuals' conception of themselves and of the self changed. They ceased to be homo totus. There was a duality to their being; the body experienced pleasure and pain and the immortal soul was released at death. The soul became the seat of individuality.

Victory over death became less certain and vision of eternal torture gained prominence. Personal immortality was associated with the belief of judgement after death - a judgement that will send the dead to either eternal bliss or eternal torture. The toll on humans' belief in survival of personality after death was a lifetime of perturbation (Toynbee, 1976:37).

Through the efforts of the church, death was viewed as God's punishment, a source of terror, not consolation. It made death the most feared moment of life. The moment of death gained extreme importance. It became the time of judgement, the moment that gave the whole life meaning. Consequently, preoccupation with death was greater during the late Middle Ages than in any other epoch in history. The preoccupation addressed the physical as well as the ecclestical terrors associated with death (Ariès 1981). According to Choron (1963:91) this acute preoccupation with death is best expressed in the words "In media vitae in morte sumus" (in the midst of life we are in death).

Other factors contributed to perpetuating the fear of death. The epoch was characterised by warfare in which vicious brutalities were common. Conditions were crowded, famine, epidemics, and pestilence were rampant. The Black Death ravaged

Europe in the 14th century. Death was everywhere. Bodies were scattered on the roads. Without sanitation and technological defences, even disposal of bodies that littered the streets became a problem. Horrendous social conditions, concomitant with the view that death was a punishment, lent terror to death (Kastenbaum and Aisenberg, 1972:195).

Art and literature of the period portrayed death as the triumphant, personified as the Great Equaliser. The conception of death in art and literature took a spectral and fantastic shape. "The macabre vision arose from deep psychological strata of fear," asserted Huizinga (1963:144). Although the fear of death was all-prevailing, it was not a taboo subject. Death was accepted as inevitable and unavoidable. The fear and horror of death were displayed openly.

Death had to be concealed. The features of the deceased engendered fear. New rites were introduced, and the body and face of the cadaver, which had been exposed to the eyes of the community, and serenely accepted, were now covered by "the successive masks of the sewn shroud, the coffin, and the catafalque or representation" (Ariès, 1981:607). It gave rise to a new taboo. Once the body was concealed, the old familiarity with death was restored. Henceforth, the concealment of the body became permanent (Ariès, 1981: 608).

"Remote and Imminent Death"

By the end of the 16th century, profound changes were beginning to take place. The concealed death with its camouflaged body began to be secretive and violent. Ariès (1981: 608) stated:

> Death, by its very remoteness has become fascinating; has aroused the same strange curiosity, the same fantasies, the same

> perverse deviations and eroticism, which is why this model of death is called 'remote and imminent'.

In a period marked by the advancement of rationalism, science and technology, and belief in progress and the conquest of nature, death, once tamed, reverted to its savage state.

It was during this period that the distance between love and death diminished. They merged in the world of the imagination. Death took on an erotic meaning. The art and literature of the period associated death with love, Thanatos and Eros. The Dance of Death theme - cavorting demons and skeletons leading men, women, and children down the paths of hell - became prominent art themes in the Ars moriendi. Death was the equaliser. No one escapes death. Death was the Grim Reaper, the Transgressor who tore people away from their families and their daily lives. It was seen as an aggressive evil force, a concept of death that had not been seen earlier in history. Ariès (1974:63) suggested that the notion originated and was developed in a world of "erotic phantasm" and then passed "into the world of real and acted-out events." Although death was not desirable, it became admirable for its beauty; it became the romantic death.

"The Death of Other"

By the 18th century the family replaced both the community and the individual of the Late Middle Ages and early modern time. A new mode of relating to others emerged. Family relationships were based on emotional bonds. Individuals became more concerned with la mort de toi, death of others, than with their own (Ariès, 1974:56). The fear of death that emerged out of the fantasies of the previous centuries was transferred

from the self to the loved one. The focus shifted from one's own death to the death of other (Ariès, 1981: 609).

> It was a revolution in feelings that was just as important to history as the related revolutions in ideas, politics, industry, socio-economic conditions, or demography.

The loss of others and the realisation "that it was only through these significant others, that one's true unique self, was made possible" (Kearl, 1989:43), transformed the meaning of death. The death of the other kindled sadness. The death of the other was no longer easily accepted as in the past. The fear of death of the other was greater than the fear of death of the self. The survivors mourned not the dying but the physical separation from the deceased. Yet, at the same time, death was seen as desirable, the long awaited refuge. It was romanticised. Ariès explained that the romantisation of death was the psychological sublimation of the erotic view of death held in the 17th century.

> Like the sexual act, death was henceforth increasingly thought of as a transgression which tears man from his daily life, from rational society, from monotonous work, in order to make him undergo a paroxysm, plunging him into an irrational, violent beautiful world. (1974:57).

Death was no longer familiar and tamed or even savage; it metamorphosed into beauty. Consequently, the belief in hell and the association between death and sin and spiritual punishment were superseded by a vision of the beyond. The next world promised to reunite loved ones separated by death. The bonds of affection on earth were to be recreated and assured eternity (Ariès, 1981:446). By the late 18th century, death of the other became intolerable.

Death of another was no longer as easily accepted as in the past. Fear of death of another was greater than the fear of one's own death. Death of another evoked fears of self-vulnerability. The permanence of society itself was threatened. Mourning became exaggerated. The need or desire for tombs and elaborate cemeteries indicated an uneasiness with memories of the dead and a need for permanence. Art, literature, and spiritual issues suggested the thought of death was becoming frightening and disturbing.

At the beginning of the 19th century, subsequent to the sudden and unexpected alteration in the mortality patterns, concomitant with the increased rates of immigration to urban areas, sanitation conditions deteriorated, causing infectious diseases to reach epidemic proportions. Death in London in 1830 was omnipresent and occurred prematurely. It was stratified by social class. Death among the gentry occurred at the average age of 44 years. Tradesmen, clerks, and their families died at average age of 25 years. Among labourers and their families, death struck at the age of 22 years of age. In 1840, in Manchester, England, the death rate for children under the age of 5 years was 57 per 100 children (Kearl ,1989:45).

In an era of the noble savage myth, the conviction that the individual is inherently morally pure, free of sins, only to be corrupted by society, the dignity and respect accorded to an individual at the time of death was to recompense for the failure to accord them in life. Wealth, produced by the socio-economic revolution, was closely associated with deliverance and respectability. Among the lower classes, the irrational need to imitate death rituals of the upper class stemmed from their need to reaffirm the importance of

their perplexing existence. More than 24 million pounds were deposited in savings banks in 1843, to pay for funeral expenses (Kearl, 1989:45).

Post-mortem Photography

The romanticization of death gave rise to post-mortem photography. In Victorian America, until 1900, post-mortem photography was socially acceptable and a publicly acknowledged form of photography. Photographers frequently advertised that they would take "likenesses of deceased persons" and that they "take great pains to have Miniatures of Deceased Persons agreeable and satisfactory, and they are often so natural as to seem, even to the Artist, in a deep sleep" (Ruby, 1988:3).

There were three distinctive portrait styles that emerged during that era. Before the 1880's, most death portraits attempted to deny death and thus the dominant pose displayed the deceased as if asleep. The "Last Sleep" reverberated the prevailing societal attitude toward death - death did not really occur, "people went to sleep" or "they rested from their labours" (Ruby, 1988:5). A variant of the "Last Sleep" pose emerged. It sought to conceal death and attempted to create the illusion of the deceased not at rest, but rather alive. To achieve the alive, yet "dead" image, the body was placed in a chair. The eyes were often open, if they were not, they were painted on afterwards. Deceased children were placed on their parents' laps or in their arms, as if asleep (Ruby, 1988:5).

By the end of the century, the deceased were portrayed as objects of grief, frequently photographed in a casket in the home or at the funeral parlour, surrounded by flowers. Often, mourners were gathered around the casket. The deceased ceased to be the

focal point of the post-mortem portrait, and attention was redirected to acknowledge both the mourners and the funeral as a social event (Ruby, 1988:14).

Cemeteries

By the end of the 17th century, the unsanitary character of the cemetery, the proximity of the living to the reopened tombs, decomposing cadavers, and toxic odours emitted became increasingly disturbing, and public opinion began to shift. The medical profession denounced the conditions that existed in cemeteries and, in 1737, it recommended that "greater care in burial and greater decency in the maintenance of the cemeteries" (Ariès, 1981:479).

Burial in the church came under attack. Abbé Porée, for example, contested the principle of ad sanctos burial, and stated that it was "contrary to public health and the dignity of religion" (Ariès, 1981:479). He requested that burial in the church be prohibited and advocated health and its precursor, cleanliness. He proposed that cemeteries be transferred to the outskirts of towns to "procure and preserve the freshness of the air, the cleanliness of the temples and the health of the inhabitants" (Ariès, 1981:479). For Abbé Porée, the milieu of the living had to be separated from the milieu of the dead.

Practice preceded rationale. With the parish cemeteries overflowing with bodies, the dead were again buried in necropolises on the fringes of towns. The justification was formulated with the development of medicine. The populace was sensitised to the health hazards of cadavers surfacing and the stench arising from common graves (Ariès, 1975:70; 1981:479).

By the end of the 18th century the cemetery was moved from the churches to the periphery. It no longer represented a functional and hygienic depository for the dead. It became a locale for memorials, piety, and reflection amidst the funerary ornaments inherited from the church (Ariès, 1981:494-496). Tombs and cemeteries, which did not have a predominant role during the Middle Ages, regained the place they had through antiquity. Although these new tombs did not contain the artifacts, iconography and inscriptions of ancient tombs, they did assure a kind of perpetuity. The memory of the dead conferred a certain immortality for the individual, while the monuments became a symbol of permanence of the society.

"The Invisible Death"

The influence of science became more apparent during the 18th century than during any other period. This change in part is attributed to the philosophical climate associated with Descartes' conception of the mind and body as belonging to different orders of reality. The mind belonged to God and the supernatural; the body was of the natural world. Subsequently, the separation of supernatural order of reality paved the way for rapid advances in the natural sciences.

By the beginning of the 20th century, the scientific method was established as the conceptual matrix for understanding the natural world, including life and death, health and disease. The development of the germ theory challenged old ideas about the aetiology of disease and death. Death was no longer perceived to be a consequence of the original sin, or divine providence, but rather a result of disease. Consequently, society's image of

death was affected. Death was no longer perceived as a sacred encounter between the individual and God. It ceased to be a spiritual matter and became an event met in an organised and rational manner. Death had been secularised. Scientific ethos replaced religious eschatology and the ecclesiastical images of death were replaced by biological reductionism. The human body was seen as an organic machine that can be taken apart and reassembled. The soul was dismissed and materialism reigned. "This mechanistic construction of the body was congruent with the mechanisation of society" (Synnott, 1993:28).

Concomitant with the secularisation of death, mortality and morbidity rates changed. Life expectancy increased and mortality rates decreased. By far, the greatest gain was among children. Nowadays, children do not frequently die; if they get sick or suffer injuries, they usually recover. More than nine out of 10 born alive will still be alive at the age of 40. Half of the population used to die before the age of 40 whereas now, half lives beyond the age of 70. Subsequently, our perception of when death occurs has been transformed. Death is perceived as something that occurs in old age (Despelder and Strickland, 1983:12).

Changing causes of death have also altered our experience of death from what it was at the turn of the century. Acute infectious diseases such as tuberculosis, typhoid , syphilis, diphtheria , streptococcal septicaemia, and pneumonia, which accounted, in 1900, for 40% of all deaths, today account for only four percent (DeSpelder and Strickland, 1983:12). The typical death, nowadays, occurs after a long progressive process

resulting from chronic and degenerative diseases such as cardiovascular illnesses and cancer.

The common scene of the natural death has shifted from the home to the hospital. At the beginning of the century, most physicians delivered medical care, such as it was and as much as there was, in the home. The traditional hospital was a place where the poor sick, deserving charity, were sent to die. Subsequent to the developments in science and technology, life-prolonging technologies and therapeutics were developed. The hospital was transformed from an institution caring for the dying to a centre where medicine and technology merged and dispensed care. The milieu of care shifted from the home to the hospital, where individuals, regardless of their social status, went hopefully to recover.

With the care of the sick transferred to the hospital, and the banishing of the elderly to nursing home, death became invisible, expelled from common individual experience. Since most deaths occur in hospitals and nursing homes, we no longer witness the whole circle of life. Most of us have experienced neither the birth nor the death of another individual. Both birth and death have been medicalised and relegated to hospital personnel.

The hospital is no longer the place where one is cured or one dies because of a therapeutic failure. It became the locale of normal death, expected and accepted by medical personnel. With the transfer of death to the hospital, death has been redefined. It ceases to be accepted as a natural process, it becomes a failure of treatment.

We no longer die of natural causes, we die of specific aetiologies. Most or all deaths could be interpreted as clinically avoidable. Death, regardless of the individual's age or illness, is seen as premature. Since we do not have a belief in some continuity between life and death and in some significance beyond the life of the individual, death becomes meaningless, uncontrollable, unacceptable, and profoundly threatening. There is a need to avoid death, deny its existence, treat it as an abnormal event distinct from life.

Death became antithetical to the image we have of what is important in life. It separates the individual from the material world, and threatens the meaning we place on material possessions (Irion 1966:21). It challenges our belief in the mythology of medicine (that historical decline in death rates was primarily a result of medical science) and the omnipotence of science. Our belief in the mastery of the individual over his or her own fate, is called into question. We no longer can believe that we are the masters of our own fate and without the solace of religion, death is a terrifying prospect. It severs the few intimate relationships we have and value. We are no longer part of an extensive kinship system with multiple relationships that meet our emotional needs. The threat to these relationships and the separations that death signifies renders us vulnerable to an impersonal and dispassionate life.

We react to the reality of death with fear and anxiety. The subject is obscene: it is pornographic. We no longer speak of death. We no longer see death. We created institutions that circumscribe our contact with death and dying. We worship youth and devalue the old. Death is relegated to the recesses of our mind, repressing the knowledge of the finitude of our existence. We shun death out of our awareness. Mourning rituals are

minimised and the symbolic representation of mourning and grief is dismissed as unnecessary sentimentality. We deritualise death. In the presence of death we tend to seek refuge in euphemistic language, substituting the harsh reality and consequences of death with vague expressions that conjure images that are less threatening, less terrifying. We refer to the dead as "passed away," "expired," "gone to their eternal reward," "departed," "gone to heaven" or "meeting his or her Maker." The coffin was transformed into a "casket" and the morgue into a "preparation room." The burial became "interment" and the mortician and undertaker were replaced by the "funeral director."

Death, according to Ariès (1981:588), no longer belongs to the dying individual; it has been regulated and organised by bureaucrats "whose competence and humanity cannot prevent them from treating death as their 'thing', a thing that must bother them as little as possible." Death has been depersonalised and bureaucratised to contain its effect on personnel.

Funerary Practices

Our funerary rites still preserve customs that were prevalent in the 19th century. These customs are an amalgamation of the of the 19th century practices of the casket and embalming, and the viewing of the body with practices brought over by immigrants (e.g., leaving the face uncovered). These funerary customs "have been adapted to an age in which death ceased to be beautiful and theatrical and has become invisible and unreal," Ariès argues. (1981:599).

Our funerary customs are reflective of our attitudes toward death. Funeral rites seek to reinstate the collective image of death, and to define death in such away as to comfort the living. Since ceremonies of death are responses to the event of death, as the meaning of the event changes so does the ceremony responding to it. Because of our dread and avoidance of death, we have minimised our direct contact with death and the body. The funeral industry has responded to our increased secularisation and deritualization of death by providing services that shelter us from the stark reality of death. The funeral industry is an intrinsic component in the bureaucratisation of death system. When death occurs, the body is prepared and removed without the aid and involvement of the surviving family. The casket selected by family members is bought for its superior padding, comfort and durability (Huntington and Metcalf, 1978:195). The deceased is seen by the family only after he or she has been prepared by the funeral establishment.

The objective of all the concentrated effort and attentiveness devoted to the corpse by the funeral director is to create the illusion and a "semblance of normality" (Mitford, 1978:71) and "to obscure blemishes and injuries" (Polson and Marshall, 1975:345). Armed with restorative waxes, plaster of Paris, face formers, denture replacers, liquid sealers, pins, scalpels, scissors, wires, masking creams, massage creams and cosmetics, the funeral director/restorer/embalmer tackles the body to put on the finishing touches that would render to the corpse a lifelike appearance. After the restoration is completed, the body is dressed with clothes that are co-ordinated with the casket interior, hair is shampooed and set, nails are manicured and the corpse is "casketed". Care is being taken to place the body in the coffin in such away as to prevent creating the impression that the body is in a

box (Mitford, 1978:74). The illusion is further achieved by turning the body a bit to the right to soften the appearance of lying flat on the back. The hands are positioned slightly cupped to convey a lifelike relaxed image. The casket is then placed in the "slumber room" for viewing.

It is extremely important to us to create the illusion of life. This illusion enables us to overcome the anxieties engendered by death, and to behave as if the deceased were alive, and thus approach the body. The embalming serves less to honour the dead than to maintain an appearance of life to protect the living from having to confront their own mortality. "The most ridiculous and irritating aspects of the American ritual, such as the making up of the body and the simulation of life, express the resistance of romantic traditions to the pressure of contemporary taboos" (Ariès, 1981:600).

Ceremonies surrounding death have been altered as the meaning of death has changed. Societies develop ceremonies and collective images that are congruent with the needs of its members. Our ceremonies of death, in which we also reflect our values and basic beliefs, are unemotional, commercialised, materialistic, and death denying.

Conclusions

Myriad diverse beliefs, attitudes and rituals related to death have been examined here. The heterogeneity is apparent. Attitudes toward death and disposition rituals, are not merely vestiges of history, they reflect cultural ideology, have specific inherent values and serve definitive social functions. They are a confluence of religion, world view, concept of the self and others, changing mortality and morbidity patterns, socio-economic

conditions, and dominant values. Obligatory funerary rituals are representative of the cultural emblematic attributes ascribed not only to the body of the living and the dead but also manifest the culture's collective images of life and death.

CHAPTER III

METHODOLOGY

The methodology applied to gather data for this exploratory study was qualitative and quantitative. A self-administrated questionnaire was constructed by the researcher, to elicit quantitative and qualitative data from nurses working in three separate hospital settings. Several structured, open ended, face to face interviews were conducted with nurses in the initial stages of the research.

Initially, the intent of the researcher was to conduct structured, open ended, face to face interviews with nurses working in the palliative care unit at a teaching hospital in Montreal. Interviews as means of data collection were deemed the most appropriate for several reasons. The strength of a qualitative approach is the possibility of gathering data with depth and width, not limited by preconceived concepts. Structured, open ended, face to face interviews are generally more effective in eliciting "fuller, more complete responses" (Singleton et al., 1993:260) and can elucidate questions dealing with complicated concepts. In instances when a respondent might balk at replying to a tedious or sensitive question, the interviewer's "tactful explanation of the item's meaning and purpose frequently results in an adequate response" (Singleton et al., 1993:261). Additionally, the response rate, i.e., the number of individuals in the sample from whom completed interviews would be obtained, is as high as 80 percent. A high response rate is conducive to the minimisation of bias being introduced into the data (Dillman, 1978).

A structured face to face interview was conducted with the Assistant Head Nurse for the purpose of insight and understanding regarding the unique approach to nursing care provided in the palliative care unit. Subsequently, an interview guide was developed on the basis of preliminary observations and conversation with several nurses. This guide ensured that a number of topics were to be raised consistently with all the interviewed nurses.

To gain access to the nurses in the Palliative Care Unit (P.C.U.), a meeting with the Education Co-ordinator of the Palliative Care Services at the hospital was arranged and a preliminary proposal for the study was submitted. A second meeting was later sought by the Director of Palliative Care Services. During the meeting, it was suggested that the most appropriate approach to the research questions raised in the proposed study were best addressed by a quantitative methodology. Thus, a research instrument designed to facilitate quantitative rather than qualitative data collection should be utilised. The rationale was that for research to be published in medical journals, quantitative data was *en vigueur*. After careful consideration of the research objectives and expectations, a change in the methodology was adopted.

The exploratory nature of this research and the absence of direct relevant studies that examined nurses' subjective reactions to the death of their patients and to the tasks of post-mortem care presented some limitations in the formulation of the questionnaire. Singleton et al. (1993:282) stated that "(S)urvey instrument design is a creative process, partly art and partly science. Like an artist, the survey designer selects 'raw materials' and combines them creatively within certain principles of design." The "raw materials" include

such choices as open-ended responses and closed ended questions, direct and indirect questions, question and response formats, general questionnaire format, and instructions. Ultimately, the survey designer differs significantly from the artist in his or her primary concerns. The survey designer is burdened with the ultimate concern of developing a survey instrument to elicit reliable valid reports of other individuals' subjective experiences such as fears, beliefs, and opinions, whereas the artist is concerned with conveying his or her subjective experiences, feelings or views.

Designing a standardised instrument that would elicit only quantitative data was circumscribed by the lack of the researcher's knowledge of respondents' characteristics and vocabulary, and the degree of structure of respondents views. Consequently, the researcher was unable to anticipate and develop closed ended questions that would provide nurses with an array of meaningful, standardised, optional responses, without omitting important response alternatives. At the same time, the researcher attempted not to constrain and force respondents to choose among options that did not reflect their true feelings or attitudes. Secondly, since one of the research objectives was to document nurses' reactions, open-ended questions had the greatest advantages of allowing the respondents the freedom in answering questions - in conveying views, recalling events and reporting reactions. Singleton et al. (1993:283-284) recounts the advantages of the open-ended question "(T)he resulting material may be a veritable gold mine of information, revealing respondents' logic or thoughts, the amount of information they possess, and the strength of their opinions or feelings." On the other hand, closed ended questions required less effort in formulating responses and less fluency with words.

Moreover, " (T)he presence of response options also enhances standardisation by creating the same frame of reference for all respondents" (Singleton et al., 1993:284). A compromise was struck, a self-administered questionnaire that included open-ended and closed ended questions was constructed, thus allowing for quantitative and qualitative data collection.

The questionnaire developed was 12 pages long (Appendix A) and consisted of 49 questions, 16 of which were open ended and were designed to elicit description of behaviour, feelings, experiences and events. The thirty-two closed ended questions included socio-demographic data such as: age, sex, marital status, educational attainment, religion, religiosity, spirituality, years of nursing experience, years of service in the unit in which they currently worked. Among the aforementioned 32 questions, 14 direct questions were included with a response option of "yes" or "no." The direct question was described by Singleton et al. (1993:286) as "one in which there is a direct, clear relationship between the question that is asked and what the researcher wants to know."

These direct questions attempted to elicit information on a variety of issues such as: the first encounter with a dead body, subsequent experiences, and post-mortem care. In most instances, if the reply to the question was affirmative, the respondent was requested to answer the immediately following indirect question that was open ended and required a description of a particular behaviour, an emotional reaction, an experience or a particular event. The contingency questions format was utilised in order to facilitate the respondents' task in completing the questionnaire and eliminate the necessity to answer questions that have little or no relevance to them.

Several questions were designed to measure the intensity of respondents' feelings. These questions pertained to fears, emotional upset, occupational stress, religiosity, spirituality, and they utilised a Likert response scale format. The scale that represented the intensity of fear associated with touching a dead body ranged from "Not at all" (0) to "A little" (1) to "Somewhat" (2) to " Much" (3) to "Very much" (4). The scale representing emotional upset at the sight of a wrapped body ranged from "Not upsetting at all" (0) to "Slightly upsetting" (1) to "Moderately upsetting" (2) to "Very upsetting" (3). The scale for the intensity of stress engendered by the frequent encounter with death ranged from "Not stressful at all" (1) to " Slightly stressful" (1) to "Moderately stressful" (2) to "Very stressful" (3). Self-reported religiosity and spirituality were both measured by a scale that ranged from " Not at all" (0) to "Slightly" (1) to " Moderately" (2) to "Very religious" or "Very spiritual" (3). The remaining questions sought specific information regarding coping strategies, initial reluctance to handle a dead body, the frequency of providing post-mortem care, attendance at religious services, and influences in the formation of attitudes toward death.

The validity and reliability of data clearly depends on the specific measures used. In general, measurement validity refers to the extent of congruence between an operational definition and the prevalent meaning of the particular concept under consideration (Babbie, 1992:132; Singleton et al., 1993:115). The validity of a specific measurement cannot be evaluated directly. In order to evaluate validity a subjective evaluation of the operational definition must be undertaken. Two methods of validity assessment, which are based on subjective evaluation, exist: face validity and content validity. Face validity

refers to a subjective judgement of the quality of an indicator which seem, on the face of it, a reasonable measure of the concept it is intended to measure. Content validity, on the other hand, refers to a subjective judgement of whether a measurement adequately encompasses all of the meanings of the concept (Babbie, 1992:132-133; Singleton et al., 1993:122-123). To assess the face and content validity, the questionnaire, in its final format, was handed out to several members of the hospital staff among them: the Director of Palliative Care, the Head Nurse, Assistant Head Nurse, Nurse Clinician, Home Care nurse and the Palliative Care Services researcher.

To undertake research in the hospital, approval from the Nursing Research Ethics Committee must be obtained. A proposal was submitted to the Nursing Research Ethical Review Committee for approval. The proposal outlined the purpose of the study, review of relevant research, conceptual framework, expectations, definition of major variables, method, and ethical considerations. It included a consent form, a letter to the nurses, and a questionnaire. After a thorough review of the proposal, a review meeting attended by the researcher and the Head Nurse of the units involved, recommendation for modifications were made, and ethical issues were explored and discussed, the Nursing Research Ethical Review Committee granted the researcher permission to carry out the research at the hospital.

The researcher was formally introduced to the P.C.U. and Medical nursing staff by the head nurse during morning and afternoon staff meetings. After the initial introductions, the researcher explained the study and its purpose and emphasised the value of their participation. The questionnaire was handed to nurses at those meetings. Each

questionnaire was accompanied by a covering letter to the nurses (Appendix B) explaining the reasons for the study and the value of their participation. The participants were requested to complete the questionnaires at their convenience. A pre-addressed stamped envelope was enclosed with each questionnaire. To assure respondents' complete confidentiality and anonymity, the questionnaires carried no identification markings and the nurses were not required to identify themselves. Thus, with the approval of the Nursing Research Ethics Committee, the letter of consent was eliminated. Nurses were informed verbally at the meeting and in writing that, in the event that completion of the questionnaire engendered emotional distress, support services were available to them in their respective units.

During the same period, the questionnaires were translated into Hebrew and distributed to nurses in the Neurosurgery Department at a teaching hospital in Israel. Question forty-three "How spiritual would you say you are?" was eliminated from the questionnaire. It was felt that it would be misunderstood and difficult to translate into Israeli reality. Question thirteen "Since your transfer to this unit how many times did you provide post-mortem care?" was also deleted from the questionnaire. The responsibility for post-mortem care had been given only recently to the nurses in the neurosurgery unit. Previously the task was performed by an a member of the burial society. (The burial society is a religious association of men and women who oversee the preparation of the body for burial). Consequently, the question had little relevance and would not have yielded any insightful or significant information. Question number 11, "what other reservation did you have about handling a dead body? " was, in the original version of the

questionnaire, a closed ended question with fixed options for response. In the Hebrew version of the questionnaire, the question was open ended, thus allowing more freedom in responses. The nurses were briefed on the purpose of the study at a nursing staff meeting and handed a self-administered questionnaire for completion at their convenience. The nurses were requested to complete and return the questionnaires to the Head Nurse by the next day.

Fifteen self-administered questionnaires were distributed to nurses in the Palliative Care Unit and 12 in the medical unit. Fourteen questionnaires were received within two weeks of distribution. A second request yielded three more replies. Return rate from the P.C.U. was 60% (9) and from the Medical Unit the return rate was 66.7% (8), representing an average of return of 63.3%. Twenty questionnaires were distributed to nursing staff, in Israel; 15 were returned. Thirteen of the Israeli respondents returned their questionnaire the next day. A second request increased the number of questionnaires returned to 15. The return rate for the Israeli sample was 75%. The return rate for all respondents was 68.1%. (N=32).

Every imaginable sociological undertaking raises problems of ethics. These problems are inevitable whenever researchers strive to recapture empirical phenomena. The researcher's responsibility toward his or her subject is of utmost importance. He or she ought to avoid injury to the reputation of the participants caused by divulging confidential information. Confidentiality is the most familiar ethical question facing the social scientist. The promise of confidentiality is an inducement to participants for their co-operation and therefore ethically binds the researcher to honour that commitment.

In this study, the researcher followed the sociological practice of using pseudonyms to protect the possible identification of respondents. Pseudonyms or fictional names, rather than the less personal questionnaire number, were used. Only pseudonyms of first names are presented. In fact, confidentiality was maintained in asking participants not to identify themselves on the questionnaire. Pseudonyms were assigned randomly to each respondent randomly. After reviewing the data, all pseudonyms for nurses working in the Palliative Care Unit appear in the text beginning with the letter P; all pseudonyms for nurses working in the Medical Unit begin with the letter M; all pseudonyms for the Israeli nurses are Biblical. To avoid any confusion, Biblical pseudonyms starting with the letters P and M were excluded. Seven nurses agreed to be interviewed. They were assigned pseudonyms starting with the letter I. Since they did not complete the questionnaire, their demographic data was excluded, and only their recollections of post-mortem care were incorporated in the findings.

Characteristics of sample

The total sample consisted of 32 nurses of whom 27 (84.4%) were females and five (15.6%) were males (see table 3.1). Eight female nurses (88.8%) and one male (11.1%) worked in the Palliative Care Unit. From the Medical Unit there were seven female (87.5%) and one male (12.5%) respondent. The Israeli nurses included 12 females (80%) and three males (20%).

TABLE 3.1 DEMOGRAPHIC DATA BY UNIT				
	ISRAELI NURSES	P.C.U NURSES	MEDICAL NURSES	TOTAL SAMPLE
	(n=15)	(n=9)	(n=8)	(N=32)
SEX				
Females	12	8	7	27
Males	3	1	1	5
AGE				
Under 25	1	1	2	4
26 to 30	4		1	5
31 to 35	2	4	2	8
36 to 40	1		1	2
41 to 45	3	1		4
46 to 50	3		1	4
50 and over	1	3	1	5
MARITAL STATUS				
Single	4	1	3	8
Married	8	5	4	17
Common-law		1		1
Separated	2			2
Divorce		2	1	3
EDUCATION				
Practical Nurse	2			2
R.N. Diploma	8	5	6	19
Baccalaureate	5	4	1	10
Master Degree			1	1
NURSING EXPERIENCE				
Less than a year			1	1
1 to 5 years	4	1	4	9
6 to 10 years	2		2	4
11 to 15 years	2	4		6
16 to 20 years	4			4
21 years and over	3	4	1	8
LENGTH OF SERVICE IN THE UNIT				
Less than one year	1	1	2	4
1 to 3 years	4	2	3	9
4 to 6 years	1	1	2	4
7 to 10 years	2	3	1	6
11 to 13 years	3	1		4
14 years and over	4	1		5
RELIGION				
Roman Catholic		4	3	7
Protestant		3	5	8
Jewish	11	1		12
Muslim	4			4
None		1		1

The sample was diversified in age. The ages of the respondents ranged from less than 35 to over 50 years. Among the nurses working in the P.C.U., 44.4% (4) were between the ages of 31 and 35 years and 33.3% (3) were over the age of 50. Of the nurses working in the Medical Unit, 2.5% (5) reported being younger than 35 years of age and 25% (2) were older than 46. The remaining 12.5% (1) were between the ages of 36 and 40. In the Israeli sample, 46% (5) of the respondents were younger than 35 years of age and 40% (6) were between the ages of 41 and 50. Only 6.7% (1) of the nurses were more than 50 years old.

Most of the nurses (59.4%) were Registered Nurses and 6.3% were Graduated Practical Nurses. A Baccalaureate degree was reported as the highest level of educational attainment by 31.3% of the nurses. Of the sample, only 3.1% reported a graduate degree (M.A.). Among the nurses working in the P.C.U. , the majority (56.5%) were Registered Nurses and 44.4% had a Baccalaureate degree. Similarly, among the Israeli nurses the majority (53.3%) were Registered Nurses, and 33.3% had a Baccalaureate degree. Among the nurses in the Medical Unit, the vast majority (75%) were Registered Nurses.

The respondents varied in nursing experience. More than 11 years of experience was reported by 56.3% of the respondents. Of these, 25% had more than 21 years of nursing experience. Of the nurses working in the P.C.U., 88.9% had more than 11 years of nursing experience. Among the Israeli nurses 60% had reported 11 or more years of nursing experience. By contrast, 87.5% of nurses working in the Medical Unit reported less than 10 years of experience.

The majority (55.5%) of respondents from the P.C.U. reported working in the unit more than seven years. Of these 33.3% worked in the unit seven to 10 years and 22.2% worked more than 11 years. Among the Israeli respondents, the majority (60%) had worked in the Neurosurgery Unit more than seven years and 40% reported they had worked in the unit more than 11 years. By contrast, 50% percent of respondents worked in the Medical Unit three years or less. None of the respondents from the Medical Unit reported having worked in the unit for more than 10 years.

Among the Israeli respondents 73.3% (11) reported their religious denomination as Jewish and four (26.7%) reported as being Muslims. Of the P.C.U. respondents 44.4% (4) reported Roman Catholicism as their religious affiliation, and 33.3% (3) Protestanism. Only one nurse (11.1%) reported not belonging to any religious denomination and one other nurse reported being Jewish. The majority (62.5%) of respondents working in the Medical Unit reported their religious denomination as Protestant, and 37.5% reported being Roman Catholic.

Among all of the respondents (N=32), 56.3% were married, 25% were single and 15.7% were either separated or divorced. No marked differences, in marital status, were noted among the respondents in the three separate hospital settings (see Appendix C).

The Palliative Care Unit

Medicine has been historically divided into two categories of care - curative and palliative. The goals of palliative care are fundamentally distinct from the goals of curative care. To palliate is defined as to relieve without curing, to mitigate, to alleviate. Palliation

means affording relief but not a cure. Priority is assigned to helping patients to accept the inevitable death with comfort and dignity. By contrast, in curative or intensive care, priorities are placed on combating death with vigorous utilisation of the most current therapeutic advances and medical technology.

In spite of therapeutic advances in cancer treatment, the mortality rate among those diagnosed with cancer (except non-melanomic skin cancer) continues to be 52%. An estimated 56,700 Canadians died of cancer in 1991. The vast majority of cancer patients die in a hospital (National Cancer Institute of Canada, 1991). The Vancouver General Hospital (VGH), for example, reported that of the 139 patients admitted to the Palliative Care Unit, between April 1 and September 30, 1991, 98% were diagnosed with cancer. A total of 118 patients (74.7%) died in the unit (Tong et al., 1993: 34).

The last decade has witnessed an unprecedented growth in the development of palliative care programmes across Canada. The structure and functions of these programmes vary greatly from palliative care units based in acute care hospitals to free-standing hospices and community based home care palliative care programmes. The Canadian Palliative Care Directory for 1994 listed 430 programmes, of which 192 were hospital based. Most of these were multidisciplinary consultation teams, however, 54 hospitals have grouped palliative care beds into one geographical location. In 1994 a total of 1246 beds in Canada were designated for palliative care.

Palliative care is a programme of active, compassionate care primarily directed toward improving the quality of life for patients for whom cure and prolongation of life are no longer realistic or appropriate goals. Palliative care "means symptom control by a

health care team skilled in clinical pharmacology" (Wilson et al., 1978:10). It is delivered by a multidisciplinary team that provides sensitive and skilled care to ameliorate the physical, psychosocial, and spiritual components of "total pain" and to meet the needs of the patient and the family. Care is provided in a hospital unit (P.C.U.) to terminal patients in three categories of need: 1) Terminal care for patients for whom dying at home is not possible due to the severity of their symptoms and/or lack of resources to provide care; 2) care for patients who still have significant life expectancy and are admitted for short stays for symptom control; 3) Respite care to patients whose symptoms are controlled, but who require 24-hour nursing care, for a pre-arranged stay for rest for both patient and families (Tong et al., 1993:32).

The decision for transfer to a Palliative Care Unit is made by the patient's attending physician. The decision for admittance into the Palliative Care Unit is based, however, on an assessment made by the head nurse and the unit's physician. Priorities for admission are given to: 1) patients from other units who manifest physical symptoms that are difficult to manage and thus poorly controlled in those units, or patients in difficult psychosocial circumstances. 2) Patients that are in the home-care programme and require admission (Wilson et al., 1978; Tong et al., 1993:32).

Most of the referrals (76%) at the Royal Victoria Hospital (RVH) were made by physicians on the medical or surgical units (Unpublished statistics). VGH reported that most patients (76.6%) were admitted from home directly or via the emergency room. Only 23.4% were transferred from within VGH or other institutions (Tong et al., 1993: 34-35). The range of a stay at VGH was six hours to 142 days. The average length of a stay was

17.9 days. The majority (73%) of patients stayed in the unit between two and 30 days. Similarly, at RVH the length of a stay for a significant number (83%) of new admissions was less than one month. The average stay was 16.5 days. Only 15.2% and 16% of the admitted patients at the RVH and VGH units respectively, were hospitalised for more than 30 days. These lengths of stay averages are consistent with the goals of palliative care of providing short-term admissions for the purposes of symptom management, respite and terminal care. Lengthy stays were indicative that "some patients' course of illness, including their psychosocial needs, required an extended hospitalisation in palliative care, and some patients remained on the unit awaiting transfers to an appropriate facility" (Tong et al., 1993:35).

Death is a frequent visitor on the Palliative Care Unit. The RVH reported that 216 individuals (78%) died in the unit in 1993. Similarly, the VGH reported that 118 (74.7%) of the patients admitted to the unit died during their stay (Tong et al., 1993:35). These high percentages of deaths are indicative of the large number of admissions for terminal care. Moreover, some patients admitted to the units for respite care or symptom management die during their stay due to changes in their condition.

Limitations

The limitations of this study should be noted. Caution needs to be taken in not generalising the results of this study to all palliative care, neurosurgery and medical nurses. Nor should the results be generalised to all Israeli and Canadian nurses. Perhaps those who have completed the questionnaires were not representative of the entire nursing personnel in these units. After a quick review of the questionnaire, some nurses may have decided not to complete it for a variety of reasons: being labelled as anxious about death-related issues, stressed or being emotionally distressed by their recollections. Others may have feared disclosing their experiences or having their response compared to those of other nurses. Although nurses were guaranteed anonymity, some may have feared being identified.

CHAPTER IV

POST-MORTEM CARE

This chapter includes descriptions and analyses of nurses' personal recollections and experiences in providing post-mortem care. It explores nurses' reactions to specific aspects of post-mortem care and the emotions they engender. The chapter is divided into two sections: the dead body and post-mortem care. These subsections are not mutually exclusive, however, since nurses' experiences performing post-mortem care include reflections on the dead body, and the subsection on the dead body include snippets of memories dealing with post-mortem care.

The Dead Body

A synthesis of social and biomedical factors have contributed and fostered our cultural estrangement from death and our increased societal fear of death. Changes in disease patterns, demographics, family composition and structure, urbanisation and secularisation of contemporary society, have all contributed to the transformation in the death and dying milieu. Ninety per cent of all urban deaths occur in hospitals, nursing homes, convalescent facilities, and retirement homes. Consequently, the opportunity to witness death among one's family has greatly diminished. Death is no longer a common experience. Death has become a mystery. It is now a rare phenomenon for an individual

to have seen an untreated dead human body. Our estrangement from death contributed to "a piece of domestic technology familiar in most nineteenth century households - how to deal with the corpse - to vanish" (Feifel, 1977:5).

Knutson (1968) reported that data obtained from a sample of 124 health-care professionals (excluding physicians and nurses) suggests that their exposure to death prior to their professional training was very limited. About half recalled seeing a dead body prior to entering high school and three-forth prior to college or professional training. Thirty percent reported being present when someone died, and 15% witnessed someone's death prior to entering college or professional training. Those who witnessed death were more likely to have witnessed it outside the home, as in an accident.

Physicians and nurses did not appear to differ from their professional colleagues. Most of the physicians and nurses interviewed reported that they had first witnessed death during their training. Those who had seen a dead body during childhood or youth reported having seen the body at a wake or funeral.

Kass (1985:21), a physician, expressed his own feeling when he encountered the mortal remains of a man he had befriended and admired for his intellectual ability, and who had died unexpectedly:

> There he lay, peacefully, a frail figure in the large bed, half smiling, as if in a pleasant dream. Dreaming, I would have thought, had I not met the nurse. Moments later, I found myself on my knees at the foot of the bed, full of awe and horror. Over and over, I asked myself, "Where is he? Where did he go ? Where is that mind, that learning and understanding, those unwritten books, that no one will now write?" There he lay, or seemed to lie, but lay not. The body, still warm and undisfigured, a body identical in looks to what I had seen the day before, mocked me with its unintentional dissembling and camouflage of extinction.

In any death, Kass further articulated, he found the evanescence of the human life, the vanishing without a trace from the human body, an unfathomable event.

A physician, interviewed for the purpose of this research paper, stated that being in the presence of a dead body engendered a multitude of emotions that were extremely difficult to articulate. The most overwhelming feeling in being in the same room with a dead body, was "being with someone, yet no one is there." Expanding on his remark, the physician said:

> There you are in the presence of a person, or what looks like a person, but there is no person there anymore. Whatever made that person unique, whatever made him a person is gone. It is this precise feeling that makes the experience extremely disturbing.

A second physician interviewed stated that the death of a patient and being in the presence of his/her body, "One is overcome by the sense of guilt, failure, and the feeling of helplessness."

This reality was reflected among some of the nurses prior to their professional training and more so among Israeli nurses. A significant majority (80%) of Israeli nurses reported that they had not seen a dead human body prior to their training. By contrast, a significant majority of Canadian nurses, 75% of the medical nurses and 55.6% of the P.C.U. nurses, have had some limited exposure to a dead human body prior to their professional training.

Consistent with the estrangement from death and the dead mentioned by Feifel (1977), few nurses reported that they had touched a dead human body. A high

proportion of nurses; (93.3% of Israeli nurses; 77.8% of P.C.U. nurses and 50% of the medical nurses) reported they had not touched a dead human body prior to their training.

Death inspires a host of intense and mixed emotions: fear, sorrow, anger, pity, powerlessness, helplessness, and resignation. Becker and Bruner (1931) and Westermarck (1906) proposed that fear of the dead emanated from an innate fear or some perceived attributes possessed by dead spirits and cadavers. Hertz argued that the "gradual elimination of the social person of the deceased and the effects it has on the status and self conception of the living" (cited in Huntington and Metcalf, 1979:65) evoked fear of the dead.

Most of the nurses admitted they feared, to some extent, touching a dead human body at the start of their nursing careers (see table 4.1). The intensity of their fear was self-reported and measured by a scale that ranged from "not at all' to "very much." A proportion as high as 44.4% of Palliative Care Unit nurses reported they did not fear touching a dead body at the start of their nursing training, in contrast to 25% of the Medical nurses and 20% of the Israeli nurses. The highest proportion of nurses who reported fearing a little the dead body were Medical nurses (50%) while lower proportions of Israeli nurses and Palliative Care Unit nurses reported the same level of intensity of fear (26.7% and 11.1% respectively). Among the Israeli nurses a higher proportion of nurses (53.3%) reported the intensity of their fear was between "somewhat" and "very much." The proportions among Palliative Care nurses (44.4%) and Medical nurses (25%) were substantially less. The highest intensity of fear reported by the Palliative Care nurses was

"somewhat." An almost equal percentage of Medical and Israeli nurses reported fearing the tactile contact with the dead body prior to their professional training.

TABLE 4.1 FEAR OF TOUCHING A DEAD BODY BY UNIT			
Fear level	Israeli nurses	P.C.U. nurses	Medical nurses
	(n=15)	(n=9)	(n=8)
Not at all	20.00%	44.40%	25.00%
A little	26.70%	11.10%	50.00%
Somewhat	13.30%	44.40%	12.50%
Much	26.70%		
Very much	13.30%		12.50%

Ingrid recalled that when she started working in the Palliative Care Unit, she had never seen a dead body:

> The sight of the first dead body evoked many emotions, but what I felt the most was fear. I knew the body could not harm me in any way and that my fear was not rational, yet I was afraid and I cannot explain it. I knew it could not jump on me or hurt me, but I felt very uncomfortable, very very uncomfortable. My work here, the handling and seeing so many dead bodies during my years of working here, diminished my uneasiness, and has helped me in my personal life. When my brother died, I was able to touch and kiss him when he was in his coffin, something I am sure I could not have done had I not worked here and been exposed to so many deaths.

The dead inspired most intense and contradictory emotions. There was a paradoxical association of feelings like reverence and disgust, inspiration and fear. Although nurses have attributed their fear myriad reasons, certain themes repeated themselves in their responses. Several nurses articulated that they feared "the unknown". Other nurses, unable to articulate or identify what they feared, have indicated they "did

not fear something specific." Additionally, "fear that suddenly the body would wake up," or "Que le patient revienne miraculeusement à la vie," or that other signs of life would appear unexpectedly, was expressed by eight nurses. Paula, a P.C.U. nurse, reflected "I don't quite remember. I just remember not having much of those experiences and would prefer to avoid it." Several Israeli nurses replied that they feared touching "a body that is considered polluted, defiled," "a body that looks so repugnant" and some reported feeling "not only fear also repulsion." Monique, a nurse in the Medical Unit, stated that she anticipated "that the person's skin would feel different or cold. I was not sure how it would feel to touch someone without life, as if I were interrupting something - some process of the transition of life to death" and thus, feared the experience. Similarly, Maureen articulated that she feared "the coldness and no response." Pauline admitted that she feared the body and felt uncertain how to treat it. She also expressed fear of being left alone with the body because "l'esprit du mort est toujours dans la chambre."

These findings complement earlier research by Kass (1985) and Lella and Pawluch (1988) who found that the sight of the cadavers produced numerous emotional reactions. Many students felt traumatised and horrified. Reportedly, some became physically ill (Kass, 1985:20). Some students reported the first incision to be the most difficult moment in their experience. They referred to the dissection as "gross mutilation," "desecration," "defiling," "violation," "butchering of the cadaver" and "committing a fundamental sin" (Lella and Pawluch, 1988:24).

The experience of touching a dead human body evoked a spectrum of human emotions for most of nurses (see table 4.2). Concomitant with the fear of touching a

dead human body, nurses have expressed many other reservations about the experience: "anxiety" (18.8%), "uneasiness" (15%), "not a nurse's job" (15.%), "loathing" (9.4%), "repulsion" (6.3%), "distaste," "aversion," and "disgust." Thirty-eight percent of respondents had no resevations about touching a dead body. When examining each unit separately,rhe responses indicate that most of the P.C.U. nurses (55.6%) reported they had "no reservations" although 33.3% reported "uneasiness", and 22.2% stated they experienced "anxiety."

Among the Medical nurses only 25% had "no reservations", 50% reported "anxiety" and 25% experienced "uneasiness"; 12.5% indicated "repulsion" and "disgust" respectively. Among the Israeli nurses a small percentage (33.3%), indicated they had "no reservations" to tactile contact with a dead human body. Thirty-three percent of the nurses agreed with Naomi, who stated that handling a dead human body was "not exactly a nurse's job, but rather a job for orderlies or someone from the burial society." Several other nurses (20%) have stated they loathe touching a dead human body. Yosef's statement represents the sentiments express by these nurses: "I loathe touching a lifeless body that often has lost all human semblance." Yael has added: "I am never willing to care for a body alone." To Shulamith, the dead human body is "defiled" and thus loathsome. Judith expressed fears of "Contagious infectious diseases."

TABLE 4.2 RESERVATIONS ABOUT TOUCHING A DEAD BODY			
BY UNIT			
Reservations	Israeli nurse	P.C.U. nurses	Medical nurses
	(n=15)	(n=9)	(n=8)
No reservations	33.30%	55.60%	25.00%
Aversion		11.10%	
Repulsion		11.10%	12.50%
Distaste		11.10%	
Anxiety		22.20%	50.00%
Uneasiness		33.30%	25.00%
Disgust	6.70%		12.50%
Loathing	20.00%		
Fear of contagion	6.70%		
Not a nurse's job	33.30%		

Total add up to more than 100% since respondents chose multiple variable.

Post-Mortem Care

Once the physician has pronounced the patient dead, a series of standard procedures are initiated. Post-mortem care is:

> a well organised routine having a characteristic temporal structuring: a clear beginning, sequence of steps, and a closure; it is done collectively, by two or more persons, and is automatically carried off (Sudnow, 1967:78).

The task effectively involves placing the body in a dorsal recumbent position. All tubes and medical equipment are disconnected and removed. All jewellery is removed and placed in a labelled envelope. Eyelids are closed and all excretions are washed off the

body with a wet towel. Dentures are inserted in the mouth and a rolled towel is placed under the chin to prop the mouth closed. The bed rails are lowered, the rolled towel is removed, and the body is covered with a sheet. Hands are exposed from under the sheet to allow family member to touch and hold them. The room is tidied and all the medical paraphernalia is removed. After the family has viewed the body, all clothing is removed. The patient's identity is verified and all addressographed ID tags are signed by two nurses. A tag is attached to the deceased's toe, and hands and feet are crossed and bound together. Nurses place a white plastic shroud under the body by rolling the body from side to side. The plastic shroud is then wrapped around the body, covering it completely. The shroud is secured by tying it at the neck , waist and ankles, mummy style. A second addressograph tag is attached on the outer tie at the waist. All of the shrouded bodies in the palliative care unit are "double bagged". In all other units, the double bagging is done only in cases involving infectious diseases. The shrouded body is inserted into a clear heavy plastic bag, and tied at the neck with a metal twister and an addressograph tag. All of the articles needed for these procedures, except the second outer bag, are found in a shroud pack (see Appendix D). These are usually kept in the utility closet of the unit. Once the body is wrapped and identified, the morgue orderlies are notified.

The nurses' experiences and frequencies of providing post-mortem care varied in accordance with the units in which they previously worked in and the mortality rates in those units. The majority of nurses (66.7%) currently working in P.C.U. reported that, prior to their transfer to P.C.U., they provided post-mortem care on average once a month and in some instances less frequently; 33.3% never performed post- mortem care.

Similarly, 75% of Medical nurses reported that prior to their service in the medical unit they rarely or at most once per month provided post-mortem care. Twenty-five percent reported they have never provided post-mortem care. Among the Israeli nurses: 46.7% reported providing post-mortem care once per month; 26.7% indicated performing post-mortem care two or three times a month; 20% did not work in any other unit prior to their service in the Neurosurgery unit.

For some nurses, transfer to their present unit of service increased the number of deaths they encountered and subsequently increased substantially the number and frequency of post-mortem care they were required to provide. Nurses working in the P.C.U. encountered death often and thus were required frequently to provide post-mortem care. The majority of P.C.U. nurses (55.6%) reported providing post mortem care two to three times per month; 22.2% reported four times per month; and 11.1% reported two to four times per week. All of the nurses (100%), presently working in the Medical unit, reported providing post-mortem care once per month.

Initiations to specific nursing tasks are often fraught with anxiety. A sense of inadequacy induced by the lack of experience and skill engender anxiety for many student nurses and recent graduates. The anxiety level intensifies when the task at hand involved a dead patient. The fact that it was the nurse's initiation to the task of post-mortem care made many of the described experiences memorable, the presence of an instructor or a supervisor heightened the anxiety felt by the nurse. Patty recalled:

> As a student nurse, the instructor thought it would be a good opportunity for all of us (6 students) to wrap a body. It was very awkward, our anxiety was heightened by each other's anxiety. One or may be two students would have sufficed with the instructor. There was nothing particular

that made it stand out except it was the first time.

For Shulamith, it was her first encounter with a dead body and the "the realisation that a human being amounts to nothing," that left a powerful a impression.

A nurse's emotional reaction during post-mortem care made this first experience a lasting memory for Monique:

> I was helping the nurse who was actually in charge of that patient when the nurse started to cry! We were both new grads, I found it strange that I didn't feel like crying whereas the nurse was very affected. I felt more that this patient was better off where she was. So it did not sadden me to see her misery relieved.

Paige recalled her own inappropriate reaction:

> We were told we had to wrap this body and remove all kind of tubes and I just kept laughing and laughing and I was upset because the family was outside the room and I couldn't stop laughing but I didn't find anything funny.

Being confronted by the grief expressed by the bereaved family, the raw emotions, the insurmountable pain "it was their screams, their attempt to touch the body and their inability to tear themselves away from it" that remained etched on Yael's memory. The reality of death is confirmed for some nurses by the appearance and the inanimateness of the body. Rachel remembered the body's "resemblance to a waxed doll." Evidence of the physiological changes that occurred after the somatic death left a lasting impression on Tamar. She recalled the "appearance, the colour, the smell." Shulamith remembered the distress she felt when she observed "the stains that were on the body and the horrible look on the face."

Sharing the task of post-mortem care with another nurse usually made the experience less traumatic. For Mary, it was not only the presence of another nurse but the fact that the nurse had a sense of humour that made the experience "moins tragique ou atroce" yet memorable. She described the death scene:

> C'était un corps dont émanait des odeurs nauséabondes et dont les liquides corporelles s'écoulaient par les orifices. C'est nauséabond et dégueulasse.

Providing post-mortem care to the first patient she cared for and the sense of loss she experienced when the patient died made the experience memorable for Pamela:

> She was my first patient. I cared for her for several weeks and I felt very close to her. I remember feeling overwhelmingly sad wrapping her body because I knew that I would never be with her again.

Recalling the first patient for whom they provided post-mortem care was reported by 87.5% of the Medical nurses. By contrast, the majority (66.7%) of P.C.U. nurses and 60% of the Israeli nurses indicated they had no recollection of the first deceased patient for whom they were required to provide post-mortem care.

Wolf (1988) reported that the some of the participating nurses in her ethnographic study, while reflecting on post-mortem care, seem to seize on the opportunity to recapture the intensity of a previous experience that was not sufficiently dealt with the time the experience occurred, and thus was stored below the surface of their awareness. The first experience in giving post-mortem care was readily described by nurses whenever the subject of death was introduced. According to Wolf, the nurses remembered many details of their first post-mortem care experience. Their ability to treat death as a

professional was tested during this initial experience with post-mortem care. A high percentage of P.C.U. nurses (88.9%) and Medical nurses (62.5%) reported having other memorable post-mortem care experiences that left a lasting impression. By contrast, the majority of Israeli nurses of 73.3%) claimed that they did not recall any other post-mortem care experiences.

A variety of reasons made an event or experience stand out: unexpected occurrence, repugnant odours, disturbing sights, emotional reactions of nurses or family members, or difficulties that were encountered in performing the task. For some nurses the physical difficulties they encountered during post-mortem care left a memorable impression. Peter stated: "It is easy to remember how difficult it is to wrap a person who weights 250 lbs. or more!" His colleagues encountered a different kind of difficulty during the preparation of a body:

> A patient had a PEG tube that was to be removed from the stomach before wrapping her. Usually a simple procedure was in this case very difficult and we had to pull quite hard, one nurse held the patient, as the other nurse used two hands to pull the tube (I was holding the patient).

An upsetting sight made the following experience memorable for Monique:

> A patient passed away. The nurse and the orderly wrapped the body. The patient had had a central line removed (jugularly) after death. Later, the orderly called me into the room and showed me the wrapped body, but the white plastic shroud was saturated - soaking with blood that had leaked out of the old central line site. He told me never to do this because of the increased work I would give him. I can still remember how the body looked as the orderly turned the patient over - the blood flowed out over the bed and through the spaces of the shroud.

Marjorie recalled the following incident:

> Someone died from a nose bleed and when we found him it was all caked around his nose and his mouth and his eyes were wide open and it was in a single room. The lights were dim and it was really quiet in the room. It was kind of spooky!

Paula remembered a patient whose body was ravaged by disease:

> A man who had his two legs amputated and was infected to the lower part of his body. The smell was horrible and the appearance of his body was putrid.

An expression on the deceased face and the circumstance of the death stayed with Pauline:

> Je trouve la patiente morte en essayant de passer par dessus les cotés du lit. Elle avait une jambe en dehors, elle était sur le coté, toute bleue et froide, et une terrible expression sur le visage.

Melissa recalled the overwhelming sense of helplessness and frustration she felt when she had to tell the parents of the sudden death of their blind son. Her frustration stemmed from her inability to support and comfort the family, because of her own fear and shock.

At times, the sharp distinction between life and death became obscured by unexpected physical manifestation. The expression on a deceased person's face, the impression of restful repose that was contradictory to other death scenes she had witnessed, made the experience memorable for Penny: "An Indian lady that looked so peaceful once dead, as if she were sleeping. She was not emaciated and still had her own clothes."

The ability to identify with the deceased caused Pierrette to remember the following experience:

> At the age of 23, on an active oncology floor I cared for a newly diagnosed leukaemic girl (age 23) who died within 3 days of diagnosis. The nurse who wrapped the body

> with me said: 'she is so young ..the same age as you!'
> At the time, I felt like it didn't matter, but perhaps it did!

Iris recalled an extraordinary wrapping:

> It was a young Chinese man who had died and in his religion it was very important that they are fully clothed. Wrapping his body after he had died, right down to his sneakers on his feet, was just ... It meant so much more than wrapping a body. It became much more like that person because of the clothing. I mean it was more identifiable as being a real person instead of a body. It was kind of like wrapping a Christmas present, more than just sending a body to the morgue.

Post-mortem care engendered myriad emotions for the nurses. The majority of nurses felt "sadness" for the patient and the surviving members of his or her family. Some nurses experienced a sense of "relief that the patient isn't suffering anymore," accompanied by a sense of "peace" and "calm." Patty, at times, "felt relief because I feel the patient is liberated. I usually say a little prayer to myself for the journey of their spirit and for the mourners." She reflects on the "frailty of life, literally one minute you are here and the next you are gone. My own and my loved ones' lives are so frail." Yet she feels grateful, "I feel thankful it is not I or some one I love but I know one day it will be, so until then I live each day to the fullest."

The need "to maintain the dignity" and "to show respect" to the deceased patient was mentioned by several nurses. Monique articulated this need:

> I want to give the patient as much respect as I can. I feel the soul is still in the room looking down at himself and feel inappropriate talking general talk, chit chat, while wrapping him .

For Marc the experience was always a "strange" event. He felt torn between his professional responsibilities and his personal need to show the outmost respect to the

deceased. Often, he recounts: "Je me sens bousculer par la charge de travail qui nous est imposée et la responsabilité et le respect que je dois a cette personne."

For Melissa, post-mortem care is an occasion to reflect on life and the passage from one state of existence to another and "surtout ce que représente le souffle et savoir vraiment ce que c'est respirer et expirer." For Pauline "l'esprit est la personne" thus the human remains are of no importance. Maxime expressed the hope that the deceased "is in a better place (heaven)."

Peter stated:

> There is always the "awesomeness" about death. It is totally incomprehensible. Each person is unique in the universe, and as one dies, another unique page is turned. Someone will mourn the loss, yet life goes on, and for us a new patient will replace the dead one.

He further reflected on death and his own mortality:

> Then there is always the question what is after death for them and eventually for me. Then there is the question about the naturalness of death, it is the one trip in life reserved for all of us. How natural can it be?

Several of the Israeli nurses expressed "anger" and "frustration." These emotions were engendered by a profound sense of failure. Yael articulated the feeling: "I felt angry that we failed to save him." Consequently she "was reluctant to touch him , but I didn't have any choice." For Naomi, the anger was precipitated by the fact that she had to perform the post-mortem care. She stated "I am angry and I complained throughout the post-mortem care that it is not a nurse's job." Esther, Rachel, and Judith expressed "repulsion and fear". Esther's statement was representative of the feelings expressed by the two other nurses: "I didn't want to be alone, I called another nurse. I was afraid and

repulsed." These feelings were share by Paige whose own fear emanated from a concern that the patient was "not dead and I am sticking him or her into a plastic bag." Furthermore, she felt "a bit of aversion to not a pleasant task." Paula, like some of her Israeli colleagues, confessed to perturbation with post-mortem care:

> I feel that it should not be my work sometimes. This is the worst task in my daily work as a nurse. I feel most of the time really strange inside. Some times I would like to be a 'robot' doing this technical thing: wrapping a dead body that was alive few minutes ago when you really cared for him.

Sarah, Rivka, Leah, Devorah and Patricia admitted that they got used to performing post-mortem care and disassociated themselves emotionally and "felt nothing" during post-mortem care. It's a task that has to be done. However, Patricia qualified her statement by adding "if I have been very attached to the person there is sometimes some reflection."

Most of the nurses (59.3%) admitted that there are situations in which they find it difficult to provide post-mortem care. No significant differences were noted among the three groups of nurses. There was no apparent consensus among the nurses on the circumstances that made post-mortem care emotionally difficult task. Some nurses found that caring for a particular patient over a long period, and developing deep emotional bonds, becoming "affectionate" and " attached" to the patient, affected their perceived emotional difficulty in performing the task. Over and above grieving for the loss of the patient Pauline stated "c'est moi qui doit le mettre dans le sac pour l'envoyer a la morgue."

Many times, immediately after the death, new patients occupy the rooms,

allowing little opportunity for nurses to process their feelings before they are expected to provided highly challenging care to a new patient.

The death of a patient in P.C.U. and the subsequent post-mortem care did not cause any psychological discomfort for Patty. She explained:

> Not on P.C.U. I know it's coming and I feel that we as a team have made the inevitable death more comfortable. On a medical floor, when someone wasn't expected to die I found it difficult. Especially after a code 99. I have been involved in two cases and both times I was doing chest compression I felt I had the patient's life literally in my hands, and it slipped through. Doing the code there were at least ten people there; after, you are alone to collect his things and deal with the family.

A long hospitalisation period increases the nurse's interaction and involvement with the patient's family members. When the patient dies, the nurse often feels "some of their pain and loss." The family's reaction to the death of their loved one heightens the nurse's own emotional response to the death. In some instances the nurse is overcome by a sense of "helplessness" and "powerlessness" when confronted by the family's grief.

The age of the deceased patient and of those he leaves behind affected some nurses. The younger the deceased patient or/ and his survivors, the more it emotionally affected the nurses. The nurses' reported they experienced increased difficulties providing post-mortem care to" a child" or "if the deceased is very young" and the survivors were young children.

Social worth differs according to age and social status. Sudnow (1967) reports that nearly everywhere in the hospital nursing personnel are able to report the number of children's deaths they have witnessed or were involve with in any way. Efforts to save lives appear directly related to social status and moral characteristics evidenced by

intoxication, drug addiction, suicidal tendencies, or criminal activities. The youth and children in critical condition are more likely to receive strenuous heroic efforts by the medical staff than the elderly patient in critical condition. Often, when a child dies, nurses break down and cry. Ordinarily employed procedures of treatment are abandoned. Organisational routines cease to have meaning. "Nowhere was this disruption clearer than with the death of children," Sudnow observed (1967: 100-109).

Unexpected deaths are emotionally problematical for some nurses. The combination of an unanticipated death and the need to carry on and perform post-mortem care while attending to their own emotional needs of grieving the loss, was reported to be emotionally taxing. For others, confronting their own mortality while providing post-mortem care contributed to some psychological discomfort and made the experience emotionally difficult. Shulamith, for example, confessed having "thoughts of how would I look after death" while she performed post-mortem care.

Certain aspects of the post-mortem activities were described, by some nurses, as emotionally difficult to perform. "Touching the body," "the odours," "removal of the tubes, cleaning the excretions," "having to look at the face," "attaching the I.D. tags," the "wrapping of the body" in the shroud; all of these aforementioned activities were reported as factors contributing to the distress these nurses experienced while providing post-mortem care.

In response to the question whether there has been a time when post-mortem care has been a positive or rewarding experience, 55.6% P.C.U. nurses and 75% of the

Medical nurses reported having had such an experience. On the other hand, 93.3% of the Israeli nurses reported not having had any positive or rewarding post-mortem experience.

Nurses considered the experience positive or rewarding when death was a "deliverance" and "ended suffering." Monique's articulation recapitulated the sentiments felt by many nurses:

> A patient was dying and going through tremendous pain, it was evident on the patient's face - the agony. After the patient died his face was so tranquil - a look of peace I'd never seen before. It made me feel that this person was really in a better place without pain.

Having "a quite peaceful time" to reflect on life in general, and the patient's in particular, sharing the task with another nurse while reminiscing about the patient, provided nurses with a sense of closure -" it finalised the care" and "completed the case." For others, the knowledge that they provided physical care, had helped to diminish the patient's suffering, provided psychological and emotional support to the family and facilitated post-mortem care made it a positive satisfactory experience. For Melissa:

> Des fois en prenant soin d'un patient, tu te rapproches de lui et tu arrives a ne pas pouvoir supporter de le voir souffrir et tu ressens un sentiment de soulagement en voyant expirer le client et reconnaissant aussi avoir bien agi en prenant soin de lui et en donnant le bon support aux parents, tu sens le sentiment de satisfaction et de sérénité.

Most of the Medical nurses (87.5%) and the P.C.U. nurses (77.8%) continued to consider the body as a patient throughout the post-mortem care. By contrast, only 33.3% of the Israeli nurses continued to view the body as a patient. Of the nurses who continue to regard the body as a patient, all (7) of the Medical nurses; five of P.C.U. nurses; and three of the Israeli nurses replied that viewing the body as a patient requiring nursing care

facilitates the task of post-mortem care. Maxime commented: "you have to, to show respect."

Several facets of post-mortem care were listed, by the nurses, as contributing factors to the unpleasantness of the task. For some nurses the whole procedure is unpleasant from the removal of the tubes and the washing of the body to the wrapping in the plastic shroud. Other nurses found the excretions and odours that emanated from the body" repulsive" and "nauseating." Wrapping of the body and covering the head in plastic was cited by several nurses as an unpleasant task. Paula succinctly stated: " The person, who you cared for, is in that bag no more a person but a 'cadaver'. To pass from having had a relationship to nothing with the same 'body' is difficult." For Pamela "it is disrespectful to have to manoeuvre the body to accomplish the task" of inserting the wrapped body in a clear plastic envelope.

Ida expressed her disdain over the need to manoeuvre the body:

> When we have to move the patient a lot in order to insert him in the second bag. It's horrible. The wrapping with the shroud is not that bad, but with the second one you have to move so much the body. Once I felt that a bone broke, and I couldn't believe it ! It's hard physically and I have the impression that I am wrapping a piece of meat.

Several other nurses mentioned that the insertion of dentures in the patient's mouth, after the death, is extremely unpleasant. Patty described the difficulties encountered: "mouths are often misshapen and the patient has not worn them in a while, it is hard to get their teeth in place and once they are in it looks freakish. I really hate that and I rarely do it." For Esther and Yael, it is "the fear of the spirit that is present in the room" after the patient died that made post-mortem care an unpleasant experience.

Paige reflected:

> The body is decaying. The sensory system doesn't like it! i.e. vision - shape- deformed, colour - mottled, purple; Smell- awful. Tone- cold. Hearing- sometimes weird noises. It as if the energy is gone, most of it seems to have disappeared, perhaps there is something basic on an energy level where one's energy moves away from.

Our society has a proclivity to dichotomise life and death. The transition from life to death is perceived as instantaneous, final and irreversible. The transformation from a status of patient to a status of body takes place on a continuum. Biological death - the cessation of all cellular activity - or clinical death - the appearance of death signs upon clinical examination - do not by themselves accord the deceased patient the status of a corpse. In some instances, nurses granted deceased individuals continued social existence as patients, in order to facilitate their giving post-mortem care. The majority of nurses; 77.8% of P.C.U. nurses; 50% of the Medical nurses; and 53.3% of the Israeli nurses stated that at a certain point during post-mortem care the deceased patient is transformed into "just a body." For most of these nurses the patient becomes a body at the moment of death. Peter articulated:

> At the moment of death the body is simply the 'remains' to me. The essential of the patient, his soul, his psyche - whatever you want to call it - departs. What remains is like a discarded shell - it does not contain the life force that once animated it. The life force or psyche is gone.

For Patty, "the body is just the container of the person. The body is always 'just a body' but never an object. It is a miracle at birth. It is a shell at death." For some nurses, the person ceased to exist as a patient "during the removal of equipment, especially the respirator." Irene stated that the patient is transformed into a body "once his face is

covered." Rachel and Penny remarked that a deceased patient is transformed into a body "when he is completely covered." Penny, however, added that it depended on her emotional bonds with the patient. For Michele, the deceased patient became "less a person when the body is put in bags." Monique stated that for her the transformation from patient to body occurred when "transferring the body onto the stretcher for the trip to the morgue." For Marjorie it is circumstances, rather than a moment in time, that transforms a patient into just a body "sometimes when we are really in a hurry," she laconically explained.

Florence Cohen (1978:37) studied removal practices in six general hospitals in the county of Queens, a suburb of New York City. Cohen reported that the cession of breathing precipitated a redefinition of the social status, a reflection of cognitive joining of somatic and social death:

> It is interesting to note that in all of the standard procedures in post-mortem care the individual is referred to as the patient until the pronouncement of death. Once he has been so pronounced, 'the patient' is thereafter referred to as 'the body' or 'the corpse'.

No longer does the nurse interact with a patient but rather with an "object", Cohen asserts. In communication with the morgue, code words are used by the nurses to signal the unit's readiness for the removal of the deceased from the unit to the morgue. The deceased patient is referred to as "a removal," "a package," "a bundle," or "a body" (1978:37).

Most of the nurses indicated that the part of the body they covered first, during wrapping, was the head. Paula stated: "I cover the head first. I don't know why. It is technically easier. Nevertheless, perhaps I don't want to see this part anymore where there

is no life." Patty explained her reason for choosing to cover the head first: "I find it is the most difficult and I get it over with. It is not terribly difficult, but unpleasant." On the other hand, several nurses had indicated that they cover the feet first. Monique stated she covered the feet first: "because they are narrower and are easier to cover. The face seems to be the last part you unconsciously want to cover." Wolf (1988) reported that the nurses admitted having a great deal of difficulty with covering the face with a plastic shroud. Most of the Israeli nurses, however, indicated they covered the genitals first.

The majority of Medical nurses (62.5%) found the sight of a wrapped body upsetting (see table 4.3). By contrast, a high proportion of P.C.U. nurses (66.7%) and Israeli nurses (53.3%) replied that the sight of a wrapped body was not upsetting to them. The intensity of emotional upset engendered by the sight of a wrapped body ranged from "not upsetting at all" to "very upsetting." Among the P.C.U. nurses who replied affirmatively, 40% indicated being slightly upset; 20% were moderately upset; and 20% found the sight very upsetting. Among the Medical nurses, 16.7% were not upset at all; 66.7% reported being slightly upset; and 16.7% found the sight of a wrapped body moderately upsetting. Among the Israeli nurses 12 (85.7%) replied to the question. Of these nurses, 41.7% replied the sight was not upsetting at all; 8.3% found it slightly upsetting; 33.3% moderately upsetting; 16.7% very upsetting.

TABLE 4.3 EMOTIONAL UPSET CAUSED BY THE SIGHT OF A WRAPPED BODY			
BY UNIT			
Emotional reaction	Israeli nurses	P.C.U. nurses	Medical nurses
	(n=12)	(n=5)	(n=6)
Not upsetting at all	41.70%	20.00%	12.50%
Slightly upsetting	8.30%	40.00%	50.00%
Moderately upsetting	33.30%	20.00%	12.50%
Very upsetting	16.70%	20.00%	

Nurses found the sight of a wrapped body emotionally difficult for numerous reasons. For Paula it provides time to examine, to question and to reflect:

> It is a quick "passage" from life to death. I say quick because as soon as the family is gone it is usually time for that work. The sight of a wrapped body makes me feel strange again after so many. Who am I? Who are we? Do we have a soul? Is there a God? Does life continue in another 'space'? Why is life so important? Why living? All existential questions are there in one second.

Melissa stated: "pas facile d'expliquer, mais des fois juste le sentiment qu'on n'est rien qu'un souffle." For Yosef, as well, it is a time to contemplate life and death and "the futility on effort throughout life - that ends that way." Yael admitted to always having "an unpleasant sensation and a repulsion when I see a body, perhaps because of thoughts of the mystery of the next world to where the spirit goes after death." For Penny, being emotionally upset at a sight of a wrapped body is not instinctive "it depends who the patient is. A stranger would not touch my feeling as much as someone I knew."

For other nurses, the mere fact that the body was wrapped engendered emotional discomfort. Rachel stated: "it sort of seems cruel to reduce a human being to a sack of meat covered with a plastic bag. It seems disrespectful." Michele found the sight

"dehumanising, anonymous." For Pauline, the sight made her realise the separation and loss as well as "l'humiliation." Marc admitted he found the sight: "que cela est triste et sans chaleur, je trouve le jeste dur. J'imagine des gens que j'aime un jour sera traite de la suite." To Shulamith "the mere sight of a wrapped body when the head is wrapped and its inability to breathe (although it is a body) causes me to recoil." Naomi confessed that "everything connected with death is very uncomfortable to me." Patty, on the other hand, had a more philosophical view. She had come to terms with her own mortality and found the sight of a wrapped body:

> Not terribly upsetting. Everyone's life must come to an end, including my own. When I was a teenager, a loved one died. (I have only lost one person that I was very close to.) I was very upset when they closed the casket, because I felt she was closed in. I don't love my patients, I am not finding it hard to believe they are dead. I find it more upsetting to see a body with makeup and a fresh hairdo and glasses on in a casket, then a wrapped body.

Wrapping a recently deceased patient in a plastic shroud evoked diverse reactions. Some nurses felt the plastic shroud provided the "best protection for those who care for the body" and it is "practical" because of the "excretions that might come out of the orifice or punctured wound." For Pamela, "the shroud is acceptable. The outer plastic bag makes me feel disrespectful because we must manoeuvre the body too much." Penny expressed a similar sentiment:

> The shroud does not bother me, maybe because I am used to it now. At the beginning it felt unusual. Now what I often think more about is the plastic bag that we put the patient in once he is wrapped. It bothers me more to think of the deceased patient in a 'bag'. Thank God it's not green or black!

Pauline admitted: "je trouve répugnant et humiliant de mettre le corps dans un drap en nylon puis dans un grand sac en plastic. Je ne l'aime pas. Mon esprit et mon coeur le

refuse complètement," however, despite her dislike, she has no choice in the matter and must wrap deceased patients in a plastic shroud. Michele shared Pauline's sentiments and admitted that wrapping the body in a plastic shroud is "the part I dislike the most." Melissa admitted she identifies with the body. She feels enclosed, swept by a sense of powerlessness and "m'imagine le manque d'air." Paige worries, while wrapping the deceased that he "might still be alive." By contrast, Peter rationalised:

> For me, the body is no longer the essence of the patient. I believe the 'patient' is long gone when it is the time for me to wrap what I believe is the 'remains' or the discarded shell. I often think of the departed 'patient', but only in a positive way.

Most of the Israeli nurses expressed "sorrow," "sadness" mixed with "anger." Yael, in addition to anger she felt, was overcome by "nausea and loathing." Esther admitted: "I am repulsed and I can hardly breathe when I do the wrapping." Devorah, on the other hand, admitted she often repressed her thoughts and feelings during the wrapping: "I think of other things and not about the task at hand. Sometimes I hum to myself (escaping?)." Yosef employed a similar coping strategy in order not to be "affected" by the task. Yitzhack felt "a sense of respect. To help the individual is no longer possible, the least that can be done is to show the last respects, regardless who that person was."

The majority of Israeli nurses (86.7%) replied that given the opportunity, they would delegate post-mortem care to another health care worker. By contrast, 66.7% of the P.C.U. nurses and 75% of the Medical nurses responded they would not. Of the Israeli nurses who stated that given the opportunity, they would delegate post-mortem care, the majority felt the task should be performed by someone other than a nurse. Dvir succinctly expressed these nurses' sentiments: "one does not have to be a nurse to care for

the dead." Shulamith explained: "I want to care for patients who are alive that have hope and a chance of surviving and where my care could be useful and not for a body after the end." For Rachel "he is no longer a patient," thus her nursing responsibilities ended. Ruth and Yitzhack stated they would delegate post-mortem care because they felt "caring for the living is much easier than caring for the dead emotionally and psychologically." Like Shulamith, Paula felt that, rather than providing post-mortem care, she preferred to "concentrate my time on life. To relieve pain, to care for others and have a relationship with a person who needs" her. Pauline and Paige felt that if they weren't obliged to perform post-mortem care they would prefer not to do it. For Maureen, delegating post-mortem care would spare her from performing a task she admitted is "unpleasant for my nose and my emotions." Marjorie, on the other hand, would delegate the task only "if I am really busy."

Most of the nurses who indicated they would not delegate post-mortem care equated the task with respect to the deceased patient. Peter explained: "Because I bring a certain respect for the remains - a certain respect for the departed patient when I do this task. I think it is important for me to do it - the way I do it - out of respect for the patient." Patty shared Peter's views. She stated, "I don't feel others (other than an R.N.) would have respect for the body."

For some nurses, post-mortem care provided the opportunity for grieving and for closure. Pierrette articulated the need for closure: "It always feels good to complete my grieving for a patient I cared for by wrapping his or her body. It is a way of accepting death and moving on toward life." Michele considered the task as "an extension of my

nursing care." It allowed her to show that caring continues after death and provided an opportunity "to pay my last respects, and say good bye." For others, post-mortem care was a nursing task with specific functions that had to be done. Maxime stated: "someone has to do it. If I knew the patient and respected him, I prefer to do it." Monique felt it was her "job," and claimed "It doesn't bother me enough to delegate." For Penny, it was "part of the dying process" and therefore part of her duties as a nurse.

Conclusion

Nurses reflected on their personal experiences with post-mortem care. They candidly described their feelings and thoughts about the duties they are required to perform as part of post- mortem care. Several differences were noted among the nurses with regard to their first encounter with a dead body, and the emotions it engendered. These differences can be attributed to culture and the influence it exerts on attitudes toward the dead body.

Most nurses admitted they feared the dead body at the start of their clinical training. The experience was fraught with anxiety, uneasiness, repulsion , disgust and loathing. The nurses feared the tactile contact with the cold skin of the polluted body, the deceased's spirit, a sudden spontaneous resurrection, and were concerned about their relative inexperience with caring for the dead. Among the Israeli nurses the fear was more common and more intense. Most Israeli nurses, in contrast with Canadian nurses, had not seen a dead body prior to their training. Judaism prohibits embalming, and exposing the body for viewing is not practised by Jews. Conversely, in Canadian

funerary practices, the embalmed, restored deceased is exposed for viewing and indeed is the focus of the funerary rites.

It was interesting to note that most Palliative Care nurses had no reservations about touching the dead body, whereas most Medical nurses reported anxiety and uneasiness, while most Israeli nurses expressed disgust and loathing.

The majority of the Medical nurses remembered the first patient for whom they provided post-mortem care, while most Israeli and P.C.U. nurses have reported no such recollections. These variations may reflect the difference in years of experience among the nurses. Palliative care and neurosurgery nurses are more specialised and tend to have more years of nursing experience. Thus, the time that elapsed between their first post-mortem care and this study was greater and may have contributed to their inability to recall their first deceased patient. The finitude of human existence, the heightened anxiety, the emotional reactions, the physiological changes, the odours, the intense sense of helplessness, the frustrations, and identification with the deceased, were all cited as reasons post-mortem care was a memorable experience.

Performing post-mortem care is an emotionally taxing task. Nurses acknowledged that at times they felt profound sadness, relief, anger, frustration, powerlessness, an intense sense of failure, and ambivalence. They also felt a sense of obligation to maintain dignity and show respect. At times, however, they felt there was a contradiction between the demands of the unit and their own need to show respect to the deceased. The need to attend to other nursing duties infringed on the time they felt they needed to provide

post-mortem care with respect. For some nurses performing the task was a time of reflection on the awesomeness of death and the incomprehensibility of nonexistence.

Post-mortem care was considered a rewarding experience, by nurses, when death ended prolonged suffering, and the physical care and emotional support they provided diminished the suffering. Almost all of the Israeli nurses did not have an experience with post-mortem care they would consider as rewarding.

The cessation of breathing brings about a redefinition of social status. Somatic and social death are linked. For some of the nurses, the patient becomes a body at the moment of death. For others, the transformation in social status from a patient to a body occurs at some point during post-mortem care. The majority of Canadian nurses continued to consider the body as a patient. This illusion of lingering life facilitates, for some nurses, the tasks of post-mortem care. For them, the transformation from patient to body takes place once the body is wrapped.

Several facets of post-mortem care were reported as contributing factors to the unpleasantness of the task: the wrapping in a plastic shroud, the odours, excretions, and the insertion of the dentures. Most nurses admitted having difficulties with covering the patient's face, thus some nurses would cover it first in order to get it over with, while others would leave it for last. Most Israeli nurses felt the need to protect the patient's modesty, thus, they covered the genital area first.

Wrapping the body in a plastic shroud evoked diverse reactions. Some nurses accepted the practicality and protection the plastic shroud offers, while others admitted it was the task they disliked the most. They felt it was repugnant and humiliating and they

identified with the body and worried about the possibility that the patient might still be alive. Several nurses felt that placing the shrouded body in the plastic bag was the most difficult task they had to perform - it was dehumanising and disrespectful. To deal with the emotional distress they felt while wrapping a patient, some nurses repress their feelings or disassociate themselves emotionally from the task at hand.

Most Israeli nurses would delegate the tasks associated with post-mortem care to other health care workers. They resented having to perform a task they felt does not require nursing skills. Their energies and efforts should be directed to care for the living. Most Canadian nurses, on the other hand, equated the task with showing respect and as an extension of their nursing duties. Post-mortem care provided an opportunity for closure, it allowed nurses time to accept the death and complete their grieving.

CHAPTER V

MEANINGS OF DEATH

This chapter analyses nurses responses regarding the subjective meaning of death, influences on attitudes and beliefs about death, and personal views on spirituality. The chapter also examines nurses' perceived levels of stress, engendered by their frequent encounter with death and post-mortem care, and sources of emotional support. The responses, for each one of these issues, were elicited in either a single question or a cluster of questions in the questionnaire.

The Meaning of Death

Heidegger, in Being and Time (1962:290) stated, "Death in the widest sense, is a phenomenon of life." Human existence is limited. We live and die - both are inevitable when one exists. One cannot live life as we know it without eventually dying; death is the final act of living. Death is a universal experience, yet perceptions of death and the responses it elicits are diverse and vary with culture and epoch. Medicine and the law often define death as the nonreversible cessation of life processes. The emergence of new biomedical technology and the development of various transplant surgeries, in recent years, required a new definition of death. Newer concepts, such as brain death, have been added to the traditional indices of death. Our conceptions of life and death have been altered. Our beliefs about the nature of life, personhood, and the relationship between mind and body are transformed.

Apart from the legal and medical definition, death has a personal meaning - a meaning often expressed in metaphoric language that includes a multitude of images. Emily Dickinson (Simpson, 1977), for example, stated:

> Death is the supple suitor
> That wins at last
> It is a stealthy wooing
> Conducted first
> By pallid innuendos
> And dim approach
> But brave at last with Bugles...
> It bears away in triumph
> To troth unknown.

To Socrates (Plato, 1977:16), death was the "freedom and separation of the soul from the body." John Fowles (1964) in one of 28 aphorisms on death, reflected:

> Death is in us and outside us; beside us in every room, in every street, in every field, in every car, in every plane. Death is what we are not every moment that we are, and every moment when we are is the moment when the dice come to rest. We are always playing Russian roulette."

British playwright Tom Stoppard (The Oxford Dictionary of Quotations, 1992:670:7) wrote in one of his plays:

> Death is not anything...death is not...It's the absence of presence, nothing more... the endless time of never coming back ... a gap you can't see, and when the wind blows through, it makes no sound.

Others viewed death as the Grand Leveller, the Ultimate Democrat, the Gentle Comforter, the Merciful Eternal Sleep, the Liberator, the Ultimate Rejoiner, the Ultimate Solution, the Great Validator. Yet some others regard death as the Grim Reaper, the Punishment, Defeat, Separation, the Ultimate Problem, the Ultimate Meaningless Event (Feifel, 1959; Lester, 1967; Kastenbaum, 1991).

To many among us death is akin to pornography: a cultural taboo subject, banned from polite conversation and excluded from social discourse (Gorer, 1984). Few among us like to reflect on our own mortality and the impermanence of our existence. Yet, nurses in particular, must. Nurses face the spectre of death more consistently than any other group among the health care professionals. The physician's involvement with the patient terminates with the pronouncement of the patient as dead (Sudnow, 1967: 80). Nurses, on the other hand, have the most intimate contact with patients during terminal illness and are often present at the time of death. After the death occurs, it is the nurses, in most hospitals, who provide the post-mortem care.

Participating nurses were asked to convey their interpretation of the meaning of death; an interpretation, separate from the objective clinical criteria, applied in hospitals to pronounce an individual as dead. Death was perceived as the total extinction of the individual, by the majority (66.7%) of Israeli nurses, regardless of their age or religion. "Death is the end of life," they have laconically stated. Similarly, Popoff (1975) found that among Jewish respondents, in his study, 60% indicated that death was the end of one's personal existence.

The majority of Canadian nurses (53%) shared the Israeli nurses' view. Penny declared: "Whatever lives dies! Normal issue of life. In humans, death is the ending of someone made of input of many people." Paige subscribes to the Cartesian-Newtonian view that consciousness is merely the product of the brain. Paige sees death as a cessation of an organism, the absence of consciousness. " The body ends, i.e., brain, thinking and body functions cease." Yitzhack shared Heidegger's deterministic view of life and death.

Both are predetermined and therefore inevitable and inseparable. "As I received life," he stated, "I am ready to receive death." Paula shared Yitzhack's views. Death is immortal, our mortality is a certainty. Death is "a reality for everybody. And I just hope there is something else after." she stated.

To Patricia, death means:

> The final letting go of control. It is the second thing we are truly sure of in this life - we are born and than we die. I am uncertain as to my beliefs about after death - but I do have some belief in the white light, peace etc. as some people have described in the near death experience.

Most human value systems affirm love as the greatest gift and loss of affection as a tragic event. These sentiments were shared by Pauline, who sees death, as well, in terms of loss and separation. Death, explained John Carse (1980:4), is not only the organic destruction but most significantly the loss of the other in the relationship with whom we have received our own personhood. To be a person is to live in a dialectical relationship of autonomy and dependence with others.

> To be a person we must exist in a web with other persons. Death, therefore, is primarily to be understood as the irreversible damage to the web of connectedness between persons. What we experience is not the death of the other as <u>death</u> , but the sudden tearing of the fragile web of existence.

For Shulamith, death is not only the end of corporeal existence, but most tragically, the severance of love bonds, the separation from the human community, from "loving family and friends."

Both Yael and Esther perceived death as being a fearful, terrifying event. For Esther, reflecting on the meaning of death was an activity plagued with a high level of

anxiety. Death is "something horrible of which I do not want to think" she declared. Yael admitted that "death is very frightening to me." In an attempt to rationalise her fear, she alluded to the fact that her fear stemmed from fearing the unknown. "Perhaps it's because I don't know what exactly happens after death," she stated. In the 11th century, Omar Khayyam (1965), the astronomer-poet of Persia, reflected as well on our lack of empirical knowledge of survival:

> Strange is it not? that of the myriads who
> Before us passed the door of Darkness through,
> Not one return to tell us of the Road,
> Which to discover we must travel too.

The belief in an existence after death is "mankind's oldest, strongest and most persistent," Freud (1948) has argued. This hope or belief in the soul surviving in some form and, in certain cases, even an idea of the resurrection of the body is found in most cultures. Several nurses expressed the belief in some other form of existence that extends beyond the demise of the physical body. Death was viewed as a passage from one existence to another, the transmigration of the soul into another realm of existence, from the real to the ethereal. For Naomi, it's "...the beginning of something which is unclear." Judith, on the other hand, believes death represents "the end of the physical being and the beginning of spiritual existence." To Irene, as well, death does not represent an end of being but rather "a passage to a spiritual life." Marjorie expressed a similar view, yet refrained from expressing or speculating about the form such existence assumes. "Death is a new beginning. The individual's life is over on this earth but it's only the beginning on 'the other side;" she stated. For Maxime, death means "going to a better place." Mary felt that there is a predetermined purpose to our life and death. Death is a passage from one

life to another; however, existence beyond physical annihilation depends on the completion of our " mission." Patty, as well, believes that:

> Death is a passage to I don't know what. I guess heaven or hell. I think it's comparable to birth, a narrow difficult passage that takes our soul somewhere new. It is liberating. The soul leaves a diseased body.

Pierrette regarded death as part of life "the completion of life on this earth, and passing into an eternity where there can be no suffering, no pain, only rejoicing." Receiving a new body is part of the eternity she envisions.

Belief in reincarnation was expressed by Monique and Peter. For Monique death is a termination of a specific experience and the transmigration of the soul into afterlife. "I believe in reincarnation and that all lives are experiences, learning to became better beings. A death is just the end of a certain experience of many lives," she articulated. For Peter, death is:

> A mile post - being born is one mile post- there are many in life and the last is death when we go back to where we came from. I tend to lean towards reincarnation - certainly I reject both "Hell" and "Heaven". I feel quite surely that death is the entry into another part of life.

Health care professionals derive much of their satisfaction from seeing a patient recover (Bailey, Steffen and Grout, 1980). It is not surprising then, that the death of a patient often results in the loss of a relationship and a perceived loss of investment in time, energy and emotion. Since medical education deals primarily with the preventative and curative aspect of health care, death frequently has the connotation of failure. Within medical ideology, death is the final enemy, and dying serves as a visible sign of staff failure (Bohrod, 1965:811). The increased reliance on biotechnologies and myriad chemotherapies to prolong and sustain life, placing biological continuation above all else,

contributes to the pervasive attitude that death represents failure of medical expertise. Sarah, an R.N. with more than 16 years of nursing experience, exemplifies this ideology. Death, to Sarah, means "the failure of treatment."

The majority of the nurses, regardless of religious denomination, believed death to be an end of one's personal existence. No differences were found between responses of Roman Catholic and Protestant nurses. However, a marked difference was noted for Muslim nurses: all of them (4) viewed death as the absolute end. Consistently, nurses who reported a belief in the continuation of the soul after the demise of the physical body, regardless of their religious denomination, professed to being either slightly, moderately or very religious (see table 5.1).

TABLE 5.1 RELIGIOSITY AND THE MEANING OF DEATH

BY RELIGIOSITY BY UNIT

Meaning of death	The end	End of earthy life continuation of soul	Failure	Reincarnation	Separation
Religiosity					
Israeli nurses					
not at all	40.00%		6.70%		
slightly	26.70%	13.30%			
moderately					
very religious		6.70%			
P.C.U. nurses					
not at all	22.20%			11.10%	
slightly	22.20%				
moderately	11.10%	11.10%			11.10%
very religious		11.10%			
Medical nurses					
not at all				12.50%	
slightly	25.00%	12.50%			
moderately	25.00%	12.50%			
very religious		12.50%			

The majority of Israeli nurses (93%) have identified themselves as slightly religious or not religious at all, in contrast with, 56% of the Palliative Care nurses and 50% of the Medical nurses (see table 5.2). Of the Medical nurses, 50% professed they were moderately or very religious, compared to 44% of the Palliative Care nurses and 7% of the Israeli nurses. (See Appendix E for results of statistical tests).

TABLE 5.2 SELF-IDENTIFIED RELIGIOSITY BY UNIT			
Religiosity	Israeli nurses	P.C.U. nurses	Medical nurses
	(n=15)	(n=9)	(n=8)
Not at all	46.70%	33.30%	
Slightly	46.70%	22.20%	50.00%
Moderately		33.30%	37.50%
Very religious	6.70%	11.10%	12.50%

Attendance at religious services is reflective of self-reported religiosity. The majority of Israeli nurses (60%) have indicated they never attend religious services (see table 5.3) compared to 33.3% of the Palliative Care nurses and 25% of the Medical nurses. Attending religious services once or twice a year was reported by 33.3% of Israeli nurses, 22.2% Palliative Care nurses and 12.5% of the Medical nurses. Of the Palliative Care nurses, 33.3% reported they attend church several times a year compared to 25% of the Medical nurses. One in four Medical nurses attend services two to three times a month and 12.5% attended every week. Among the Israeli nurses, only one nurse (6.7%)

attended religious services each week. Similarly, only one Palliative Care nurse (11.1%) reported attending church several times a week.

TABLE 5.3 ATTENDANCE AT RELIGIOUS SERVICES BY UNIT			
Attendance	Israeli nurses (n=15)	P.C.U. nurses (n=9)	Medical nurses (n=8)
Never	66.00%	33.30%	25.00%
Once or twice a year	33.30%	22.20%	12.50%
Several times a year		33.30%	25.00%
Once a month			
Two or three times a month			25.00%
Nearly every week			
Every week	6.70%		12.50%
Several times a week		11.10%	

The Spirit and Spirituality

Soren Kierkegaard in The Sickness unto Death (1968) reflected, "Man is spirit. But what is spirit? Spirit is the self... Man is a synthesis of the infinite and the finite, of the temporary and the eternal...." Do we experience the spirit, the essence of the self, after the demise of the body? The majority of nurses have reported they have not experienced the presence of the deceased patient's spirit or energy in the room at the time of death or immediately thereafter. However, 33.3% of Israeli nurses, 37.5% of the Medical, and 11.1% of P.C.U. nurses indicated they had such an experience. These nurses have

reported a sensation that the deceased's spirit was hovering above and "watching" while they provide post-mortem care. Shulamith described one of those instances:

> While I provided post-mortem care for a deceased woman, for whom I cared for a long time, and with whom I 'connected' I had the distinct feeling, during the care, that some one was watching me and I wasn't alone in the room.

Esther and Maxime have also had similar sensations. Maxime articulated, "I always feel the patient is still in the room, watching."

Patty reflected and conveyed that most of her experiences involves an energy rather than a spirit:

> I often feel an energy in the room when a patient dies. Is it my own personal curiosity of the moment of death? I don't think so . I feel it whether I am alone with the patient or if I am with the family. It's as though the patient passes through you, above you and around you. Sometimes a patient is confused or comatose and I get that feeling. It is strange, but not uncomfortable. Some times other people sense it in the room, and sometimes they are very bothered by it. My own personal experience was with my aunt, whom I loved very much and was close to. When she died, I felt her leave and then I felt empty. It is the worst feeling I ever experienced.

Monique experienced a sense of serenity descend upon the room, immediately after a difficult death:

> I remember a patient going through a very painful death, fought for his life the whole time. I'll never forget the look of peace on his face. The room felt warm and tranquil despite the mess surrounding the patient. I think everyone felt it.

Melissa had sensed a presence in the room after a patient's death. The sensation was so real that "je tourne la tête en des directions pour voir ou appréhender," she stated.

Both Yael and Judith experienced the presence of deceased patient's spirit. Each one of their experiences involved the spirit of a young child who had died earlier. For Yael the experience was fraught with anxiety and distress. "It was a little girl who died. I

had the sensation she was a sleep and not dead. I rushed to complete the wrapping so that I could run out of the room," she recalled. Judith remembered not only the family's intense grief at the deathbed of a young girl, but also the presence of the child's spirit in the room. "The family leaned on the body and heart-rending cries filled the room. There was a sensation that the young girl's spirit circled and filled the room," Judith recalled.

Irene recounted a recent experience involving a husband granting his wife permission to die:

> I went into a patient's room to suction her. She stopped breathing and she died. The room was quite, there was no noise. The husband spoke to his wife and she came back and took two or three breaths of air. I told the husband to tell her to let go. The husband told his wife to go in peace to a better place and she stopped breathing.

When asked whether the presence of the spirit was felt in the room Irene replied: "Oh, yes definitely. I felt she was listening to him."

The Webster's Dictionary describes spiritual as: "relating to, or concerned with the soul or spirit relating to religious or sacred matters..... having a relationship based on sympathy of thought or feelings..." Davidson (1978:146) suggested that " spiritual refers both to the substance, breath or air, and the activating and essential principle that is life." The spiritual dimensions are the integrating principles of individuals' lives. These dimensions, while extremely personal, are also intrinsically social and manifest themselves in the need to be with others.

Twenty-two percent of the Palliative Care nurses described themselves as slightly spiritual (see table 5.4). Among the Medical nurses, the majority of respondents (87.5 %) indicated they were moderately spiritual. By contrast, only 11.1% of the Palliative Care

nurses perceived themselves as being moderately spiritual. However, 55.6% of these nurses indicated they considered themselves as very spiritual individuals compared to 12.5% of the Medical nurses.

TABLE 5.4 SELF-REPORTED SPIRITUALITY BY UNIT		
Spirituality	P.C.U nurses	Medical nurses
	(n=9)	(n=8)
Not at all	11.10%	
Slightly	22.20%	
Moderately	11.10%	87.50%
Very spiritual	55.60%	12.50%

There was no consensus among the nurses about the meaning of spirituality. Being spiritual had a personal subjective meaning to each one of the nurses. For some, spirituality was fraught with religious overtones. For Pierrette and Marjorie, being spiritual was synonymous with a belief in Jesus Christ as the Saviour and his acceptance into their lives. Pierrette explained:

> I am a born-again Christian who believes that Jesus Christ has died for the penalty of my sin, and arisen again to be my Lord and Savior I believe that those who accept him into their lives and make him Lord, accept and confess that they are sinners and are saved by grace, and believe that Jesus died on the cross and rose again, can live eternally with Him.

Patty was uncertain as to the definition of a person's essence of being, however, she alluded to the everlasting existence of the incorporeal being:

> I believe that within all of us there is a spirit, a life-force, a light. I don't know exactly. Most people don't take care of that part of themselves. We take care of our bodies and minds,

> feelings, but not our spirit. Our feelings are intertwined with others. It is the core of our being. It is what lives on.

Spirituality, for Peter, is to perceive and recognise the meaning of life itself, not only on a subjective level, but also, vis-à-vis the totality of all existing things and a Supreme Being. Peter explained:

> To be spiritual means to be open to and to search for a meaning in life- to try to understand what might be the nature of life, God, the universe. What might be my role in it. My relationship to God, my family, my friends.

For Paula, being spiritual equates with giving life a purpose and meaning. "Spiritual goals would be loving each other and taking care of our own life," appreciating it and cherishing life as we would a gift, she stated. For Maureen, as well, being a spiritual being meant having emotions and "feelings."

Pamela believes that part of what being spiritual means is that we are all moral beings who share a "responsibility for our actions and are accountable to each other." "Love is the essence of life," she stated. Being moral, compassionate beings, "We must share with our loved ones and those who need support and help," Pamela asserted.

For Penny, spirituality is "like meditation, working on the personal growth of yourself, your beliefs, etc." Paige, on the other hand, admitted not being certain of the degree of her spirituality. Her spirituality changes, it's situational, difficult to define:

> It varies in time and place. Perhaps easier to explain by what spirituality is <u>not</u>. It is not hatred, judgement, violence, thinking fear, greed. When these are present, spirituality is not. When those are not, perhaps, that which is compassion and love have some room.

Influences on Beliefs and Attitudes toward Death

Culture manifest itself in beliefs, norms, values and statuses. Cultural symbols and definitions are organised into shared beliefs. These are convictions that pertain to specific situations and to a shared understanding of the truth. Beliefs convey to individuals what should or ought to exist or to have occurred in a particular situation, or what will happen in the future. Beliefs also transmit codes of behaviour and expected responses in terms of feelings to a particular situation. We distinguish between existential, normative and cathectic beliefs. Existential beliefs refer to statements or claims about what is, was or will be and includes ideas about cause and effect. Normative beliefs, on the other hand, refer to what should or ought to be, especially to goodness, virtuousness or propriety. Cathectic beliefs define what is painful, and what pleasurable. They also identify what is admirable or praiseworthy. In each culture, one or the other of the aforementioned beliefs may take precedence over the other in specific situations (Hagedorn, 1980:84-87).

All of the Israeli nurses (n=15) and the majority of Medical nurses (75%) have indicated that their encounter with death and post-mortem care has not influenced their beliefs (see table 5.5). Conversely, the majority of Palliative Care nurses (55.6%) acknowledged that their beliefs were influenced by their frequent exposure to death and post-mortem care.

TABLE 5.5 EXPOSURE TO DEATH AND INFLUENCE ON BELIEFS BY UNIT			
Exposure	Israeli nurses	P.C.U. nurses	Medical nurses
	(n=15)	(n=9)	(n=8)
Yes		55.60%	25.00%
No	100.00%	44.40%	75.00%

An attitude is defined as mental feeling, state or disposition, developed and organised through experiences, which produces a tendency to act and react in a certain manner when confronted with specific stimuli (Allport, 1967:8; Oppenheimer, 1966:105-106). We thus posses both transient and relatively enduring attitudes with regard to death. The spectrum of emotional and intellectual attitudes toward death expressed by nurses varied from fear and horror to reconciliation. Nurses indicated that their frequent encounters with death influenced their attitudes toward life, death, and their religious beliefs. Melissa professed she is "more respectful of death and life" and at the same time "less fearful of death." For Monique, it reaffirms her beliefs in the endurance of the soul and in an afterlife. "It made me more sure than ever that there is life after death," she acknowledged. Death ceased to be an adversary, "Death is not a negative experience. It is a welcome event," Monique admitted. Shulamith and Esther shared the conviction in survival of the soul after death. Esther professed that "the knowledge that there is an after life" influenced her attitudes toward death. For Shulamith, the belief helped her "relate to death easier."

Patricia's religious conviction about Heaven and Hell were transformed by her frequent encounters with death:

> When I came to work here I could no longer believe that
> some of the people I cared for, were destined for hell.
> Nor, did it seem that religious beliefs influenced, in particular,
> the way people died.

Furthermore, Patricia questioned the ramifications for patient care were it not dominated by the Judaeo-Christian doctrine. "I wonder if we would care for people

differently if we believed they would all be reincarnated? Could it help us in counselling them?" she pondered.

In Patty's case, being exposed to death not only reaffirmed her belief in a Supreme Being but it taught her to appreciate life:

> It strengthened my belief in the power of the human spirit. It strengthened my belief in living each day to the fullest, enjoying my youth and health, my loved ones. My body can die tomorrow just like everybody else's. The only way to live on, on earth, is through those whose lives you have touched.

For Pauline, as well, it change her outlook on life. "Je crois dans le présent, vivre au jour le jour," she admitted.

Frequent encounters with death increased Pierrette's awareness of "the finality of death" and certitude of death, as a common destiny of all human beings. For Paula, experiences with death and post-mortem care transformed her religious beliefs. "I became more spiritual and less religious," she professed. Dvir, on the other hand, became unaffected. "After seeing several deaths one does not get excited by it," he remarked.

All of the Palliative Care nurses stated that caring for the terminally ill influenced their attitudes toward death (see table 5.6). Conversely, only 37.5% of the Medical nurses and 33.3% of the Israeli nurses identified caring for the terminally ill as an influencing factor on their attitudes toward death. Two out of three Palliative Care nurses indicated their attitudes toward death were influenced by their personal values, as compared to 75% of the Medical nurses and 46.7% of the Israeli nurses. Only Palliative Care nurses (55.6%) identified seminars and conferences as an influential factor in the formation of their attitudes. One out of two Medical nurses indicated that their death attitudes were

influenced by religious beliefs and the death of a loved one. Thirty-three percent of Palliative Care nurses and 26.7% of the Israeli nurses reported that religious beliefs influenced their attitudes toward death.

These findings tend to corroborate Hopping's (1977) results that nurses' attitudes toward death and dying were not directly influenced by a semester's clinical course. Nurses' personal experience with a family death was a more salient learning experience. Similarly, Golub and Rezinkoff (1971) and Alexander (1990) concluded that direct exposure to dying patients was the most important variable in forming nurses' attitudes toward death.

TABLE 5.6 SOURCES OF INFLUENCE ON ATTITUDES TOWARD DEATH

BY UNIT

Sources of influence	Israeli nurses	P.C.U. nurses	Medical nurses
	(n=15)	(n=9)	(n=8)
Religious beliefs	26.70%	33.30%	50.00%
Personal values	46.70%	66.60%	75.00%
Death education	6.70%		
Reference material	13.30%	11.10%	12.50%
Seminars and conferences		55.60%	
Caring for the terminally ill	33.30%	100.00%	37.50%
Death of a loved one	6.70%	11.10%	50.00%

Totals add up to more than 100% since respondents chose multiple variables.

Stress Caused by the Encounter with Death and Sources of Emotional Support

In Hans Selye's view (1976), stress represents the generalised response of an organism to environmental demands. In other words, stress can be identified as an

external agent that threatens the equilibrium of the individual. Stress, according to the World Health Organization (1971:68-178) represents the "unsuccessful attempt on the part of the organism to deal with the adverse factors in the environment." The actual environmental influence or agent, the stressor, could be physical, psychological or sociocultural. The range of possible stressors is therefore extremely wide and could encompass a variety of life events. Parks (1971) indicated that stress can stem from "psychosocial transitions". Those include both positive experiences, which involve a change in life style, and more adverse circumstances such as grief and bereavement.

The nursing literature (Holsclaw, 1965; Price and Bergen, 1977; Keane et al., 1980; Numeroff and Abrams, 1984) has suggested that certain hospital units expose nurses to higher levels of stress. Palliative care units and hospices were among those identified as units that expose their nurses to higher levels of stress (Desich, 1964; Beszterczey, 1977; Vachon, 1985). Contradictory findings were reported by Gray-Toft and Anderson (1981). Their sample drawn from five patient care units, including a hospice unit, demonstrated high levels of stress on the medical unit and low levels of stress among the hospice nurses.

A multitude of factors influence nurses' perception of occupational stress. Nurses' stress perceptions are influenced by the manner they view the process of dying, their subjective concept of death, their perceived role ambiguity, and conflict with physicians, supervisor, and other staff members. The majority of Palliative Care nurses (66.6%) professed that the frequent encounter with death is slightly stressful compared with 75% of the Medical nurses and 33.3% of the Israeli nurses (see table 5.7). The highest levels

of stress reported were experienced by a greater proportion of Israeli nurses (46.6%), compared to 33.3% of the Palliative Care nurses and 12.5% of the Medical nurses. These findings represent the combined totals for categories ranging from moderately stressful to extremely stressful.

TABLE 5.7 STRESS LEVELS CAUSED BY THE ENCOUNTERS WITH DEATH AND POST-MORTEM CARE

BY UNIT

Stress levels	Israeli nurses	P.C.U. nurses	Medical nurses
	(n=15)	(n=9)	(n=8)
Not stressful at all	20.00%		12.50%
Slightly stressful	33.30%	66.70%	75.00%
Moderately stressful	20.00%	11.10%	12.50%
Very stressful	13.30%	22.20%	
Extremely stressful	13.30%		

Few nurses reflected on the sources of stress. Michele has indicated that the encounter with death was slightly stressful, however, "it is not a negative stress. It is difficult to separate 'the death' from 'the dying' which can be very stressful," she commented. For Patty, it is not so much the death but rather "the family crisis," the anxiety and sadness experienced by family members and often by the patient that engenders the stress.

Nurses are constantly confronted with issues relating to loss. It may be loss of independence, loss of control, loss of decision-making ability, or loss of life. This constant exposure to loss and death constitutes an enormous emotional burden. These experiences are compounded by the fact that, with each death, nurses must confront their

own mortality and that of their loved ones. How do nurses cope with their own grief? How do they respond to the death of a patient? What are the sources of their emotional support?

The majority of nurses, regardless of the unit they worked in, reported they rely on informal support in the unit (see table 5.8). Formal support was utilised by only 22.2% of Palliative Care nurses and by 6.7% of the Israeli nurses. Both Medical and Palliative Care nurses turn to friends and family for support. Religion provided comfort to only few nurses. Only 22.2% of Palliative Care nurses and 12.5% of the Medical nurses reported that religion provided solace in times of grief. Some nurses employed other coping strategies. Peter, for example, meditated. Michele relied on her "own philosophical and spiritual beliefs." Paige alluded to the fact that she mastered detachment. She "just watches them come and go," she stated. Yoseph, not to be overcome by emotions, employed "denial." Patty relies on her colleagues, on her family and boy-friend and the realisation that "life and death are in the hands of God."

TABLE 5.8 SOURCES OF EMOTIONAL SUPPORT BY UNIT

Sources of support	Israeli nurses (n=11)	P.C.U. nurses (n=9)	Medical nurses (n=8)
Formal support in the unit	9.00%	22.20%	
Informal support in the unit	82.00%	77.80%	75.00%
Friends, family	9.00%	55.60%	75.00%
Religion		22.20%	12.50%
Other	9.00%	22.20%	12.50%

Totals add up to more than 100% since respondents chose multiple variables.

Conclusions

Nurses shared their thoughts and feelings regarding their individual interpretation of death and spirituality, and the influence the encounter with death had on their beliefs and attitudes. Death was perceived by the nurses in different ways: the end, the final process of life, a separator and isolator, a terrifying event, a transition, and as a new beginning of life after death. This partly reflected their diverse views on their own spirituality, and type of spirituality, if any. There was no agreement among the nurses regarding the meaning of spirituality. It had a personal and specific meaning and thus responses varied. Spirituality was seen by some nurses as inseparable from the tenets of Christianity. To others, it is a search for meaning, individual accountability, emotions, love and personal growth.

Nurses' attitudes toward death were influenced by a multitude of factors. What was surprising to me was that nurses' attitudes were strongly influenced, despite their common profession, by both culture and unit orientation. For example: Palliative Care nurses, in contrast to nurses from other units, unanimously stated that caring for the terminally ill influenced their attitudes toward death. Compared with Palliative Care and Medical nurses, the frequent encounter with death was more stressful for Israeli nurses.

The principal findings, which will be discussed further below, are:

1. Death is conceptualised in very different ways by different nurses. Death was perceived by some nurses as the end of an organism, and by others as a beginning of another form of existence.

2. While variations reflect individual attitudes they are also cultural. Most Israeli nurses saw death simply as "the end". In contrast, most Canadian nurses saw it as a new beginning or a transition.

3. While Palliative Care nursing is widely regarded as a high-stress occupation, most nurses reported that dealing with death as such is less stressful than dealing with family crisis among the living.

4. Exposure to dying seems to be the most influential factor in determining attitudes toward death and dying. Death education seems relatively unimportant compared to both the actual caring process and personal values.

5. The main sources of emotional support for nurses are the informal sources of support of the local unit. This does have practical implication for resource allocation.

6. The final point, which was the most interesting to me, is that nearly one-third of the nurses sensed the existence of an energy or a spirit in the room or around them as they cared for the body.

CHAPTER VI
CONCLUSIONS AND RECOMMENDATIONS

Our existence is finite. To paraphrase Freud, biology is destiny. Death is a biological and existential reality that affects every human society. Each culture, through belief and value systems as well as secular and religious rituals, defines the meaning of death and the mode of dying for its members. The death ethos, embedded in history, is constantly redefined and reaffirmed via rituals, language and cultural conceptions of selfhood, social structure and world view. For millennia individuals have coped with the eventuality of death. Over time there has been a slow and almost imperceptible transformation in beliefs and concomitant attitudes. Western civilisation's attitudes toward death changed, from the "tame death" to the "invisible death," as Ariès (1981) has shown. Ours has been portrayed by social scientists as a death-denying society. Death, during the present century, is a taboo topic of conversation.

Yet, dying and death have not always been perceived as a "taboo" subjects nor have they always been considered problems requiring research. A synthesis of social and biomedical factors has contributed and fostered this cultural estrangement from death and our increased societal fear of death. Subsequent to remarkable medical discoveries and advancement in life-prolongation technologies, the concept and definition of death have been altered. Changes in demographics, family composition and structure, urbanisation and secularisation of contemporary society have all contributed to the transformation of the death and dying milieu. No longer does the individual die in the midst of family and friends, in the comfort of his or her own home. The majority of Canadian deaths occur in hospitals, nursing homes, convalescent facilities and nursing homes.

The institutional context, in which death and dying is experienced, has changed dramatically. The process of dying has shifted from the moral sphere to the medico-scientific sphere. The hegemony of the priest has been replaced by that of the physician. Subsequently, the individual's exposure to dying and to death has been minimised, while the disruption, caused by death, to the family and to the social process, has been contained (Blauner, 1966: 384).

The hospital, in Blauner's view (1966:384-385), in addition to its function of isolating the dying from the rest of society, is committed to rationalisation and routinisation of death:

> Its distinctive competence is to contain through isolation, and reduce through orderly procedures, the disturbance and disruption that are associated with the death crisis.

Caring for terminally ill patients and their families is one of the most stressful events reported by physicians and nurses. The bureaucratisation and rationalisation of death in hospitals was implemented not only to curtail the reaction and disruption for family members and society in general, but also to minimise and contain the emotional reaction of hospital personnel and to ensure their efficacy, in particular. Bureaucratisation has transformed both regular and extraordinary events into organised and standardised procedures.

The rationalisation of death in hospitals occurs through standardisation and routinisation of post-mortem care. If one is to closely examine the procedures associated with post-mortem care, one observes that in effect, they replaced the "laying out of the body" of less than a century ago: an activity that was within the realm of family responsibilities to its deceased members. Rationalisation transformed the tasks, in

hospitals, into highly standardised and routinised procedures referred to as post-mortem care: a series of duties that allow nursing personnel to work with alacrity to prepare the body for removal to the morgue.

Wolf (1988) offers a divergent analysis of the tasks associated with post-mortem care and their rationale. Applying the definition of ritual of DeCraemer, Vansina and Fox (1976), Wolf contends that post-mortem care performed by nurses for their deceased patients is a bona fide therapeutic nursing ritual. As such, the succession of co-ordinated nursing duties that commence with the preparation of the body of the deceased patient, and culminate with the transport of the body to the morgue, consist of patterned symbolic healing actions that represent the nurses' moral values and norms.

The objective of all therapeutic rituals is to ameliorate a patient's condition. Post-mortem care, Wolf argues, has a latent meaning for nurses as they care for their patients after death; they continue to engage in therapeutic nursing interventions. The symbolic meaning aspect of post-mortem care, Wolf asserts, rests in:

> The nurses need to remove the manifestation of suffering, to purify the patient and hospital room from the soil profanity of death, and to gradually relinquish their tenure of responsibility for the patient, given up only as the escort personnel transports the patient to the morgue. Explicitly, post-mortem care helps make their dead patients presentable for family viewing (1988:139).

Nurses' experiences with post-mortem care and death were diverse and represented a confluence of factors. Nurses' personalities, religious beliefs, cultural value system, customs, life experiences, nursing experiences, and unit's orientation all converged and influenced their attitudes toward death and the dead.

Several possible explanations can be offered for the differences noted between Canadian and Israeli Nurses with regards to post-mortem care and death. The tasks associated with post-mortem care have been only recently assigned to nurses in the Neurosurgery unit. Prior to the introduction of this new directive, nurses were required to disconnect the patient from the equipment, remove the tubes and other medical paraphernalia, place Band-Aids on any apertures, and cover the body with a bedsheet. The orderly was called and the body was taken to the morgue. The washing and tagging of the body were done later by personnel of the Chevera Kadisha - the burial society. Nurses cared for the living; the burial society cared for the dead. As Sudnow remarked (1967) within the hierarchy of the hospital, handling the corpse is perceived as "dirty work". The new directive assigns a task low in prestige and value, in comparison to caring, healing and rehabilitating, to nursing, which is a profession higher on the hospital hierarchical rungs. The new regulation was met with resentment. Nurses felt that caring for the body, after death, did not require nursing skills and contradicted nursing objectives. It is perhaps the residual resentment that was evident in their responses and attitudes towards post-mortem care and the body.

Cultural differences in attitudes towards the dead body may have also contributed to the negative attitudes of the Israeli nurses. The Jewish religion considers the dead body as defiled and polluted. The Old Testament alludes to the concept of the corpse as a pollutant and taboo. In Leviticus (21:11) the Kohen, member of the priestly class, was forbidden to come in contact with a dead body or to enter a cemetery. It is only as a mourner, mourning the death of a significant other, that the Kohen has the religious duty

to defile himself. This law continues to govern the interaction between the corpse and Kohen and his participation in funeral rituals among Jews, worldwide.

Although most Israelis are secular, as the sample in this study indicated, the death ethos is entrenched in religious beliefs. Moreover, there is no separation in Israel between State and Religion. Religion defines who you are. Most rites of passage - birth, "coming of age," marriage, and death - are governed and celebrated with religious rituals. Religion is one of the aspects that exerts the strongest influence on the world view. While there appears to be a contradiction between reported religiosity and attitudes, most Israelis would rationalise the observance of rituals and their attitudes as "keeping tradition"; in other words, customs are observed, not from religious convictions but rather as an adherence and identification with a common heritage and group.

Until recently there was a clear demarcation between the sacred and the defiled, in the hospitals. Nurses cared for the living and the burial society cared for the dead. The separation was not only in terms of duties but also in locale. The dead were carted off to a separate part of the hospital to be administered the last care. With the assignment of post-mortem care to the nurses, the boundaries are blurred. No longer is there a clear demarcation between the pure and impure, the sacred and profane, hygiene and contagion, life and death.

The unit's orientation may have a role to play in the contrasts noted in nurses' attitudes. Work settings have their own subjective milieu and their own sentimental order. Glaser and Strauss (1965;1968) have suggested that different working situations and nursing units are characterised by different task structures and mortality rates. Each

unit approaches its work with the dying with its own philosophy. The emotional atmosphere in a hospital unit encourages a particular reaction to death. A death in a palliative care unit and a surgical or medical unit will not arouse the same emotional responses from the nurses. The type of experience a nurse acquires is influenced by the unit's orientation and sentiment order.

In a neurosurgical unit, as in all other surgical and medical units, the emphasis is on recovery goals. The duration of stay is relatively short. Most discharged patients go home or to rehabilitation facilities. The death rate is low. The most recent available statistics (unpublished unit statistics) indicate that in 1994, 1476 patients were admitted to the unit, fewer than 5% (72) died. Mainstream medicine is operating under the maxim of preserving life at all costs and above all else and is driven by the technical imperative to "cure" and "treat." Death as a possible outcome is an anomaly, a failure.

Death in Canada is a phenomenon of the old, banished from common experience and rendered invisible. We are shielded from the perpetual encounter with our own mortality. Death strikes someplace else. It happens to others. In Israel, by contrast, death is highly visible. The repeated wars with neighbouring Arab countries, the numerous violent terrorists attacks and the high number of traffic fatalities have meant that death is often perceived as extremely violent and unexpected. Deaths that strike reverberate through the entire society. Each member of society is a mourner. Personal and collective anxieties concerning destruction and nonbeing are high. Death is adventitious, it looms around the corner. It can happen to any one, anywhere, any time. Everyone is vulnerable. Death strikes young and old alike. There is a sense of loss of control and

predictability. The nation's future is threatened. Death is a destroyer, a terrifying prospect. In light of historic and present circumstances, the Israeli nurses' higher death related anxieties and fear can be understood. Objective factors affect subjective meaning. Death is not only a failure of medicine to cure and heal, but an everyday reality that threatens the sense of future of the collective and the individual within.

Implications

Though limited by its sample size, the results of the present study have several implications for nursing practices, education, allocation of resources and research.

As a result of this research study, several suggestions seem appropriate. Firstly, nursing administration should become more cognisant of the sources of emotional support nurses utilise. Most nurses, regardless of their unit of service or orientation, relied on the informal support network. Support by colleagues is mostly offered at the nurses station, during coffee breaks or lunch in the cafeteria. The findings indicate that seldom does a nurse consult the psychologist or the psychiatrist assigned to the unit. Most emotional reactions, engendered during the course of providing care, need immediate venting and debriefing. To receive formal support, nurses would have to postpone unburdening to a later day. Nurses in the unit share its history and concerns. The shared environment fosters familiarity and trust. Mutual support is offered through nursing interaction during shared tasks. The allocation of resources, such as funding, time, and personnel to maintain and offer formal support to nurses should be reconsidered in this context of the importance of the informal support system.

Secondly, the differences in attitudes between Canadian and Israeli nurses may reflect differences in training. Perhaps it is the training that contributes to the more positive attitudes Canadian nurses have toward post-mortem care. It is possible that with the increased attention given to care the of the dying, in nursing and medicine, Canadian nurses are ultimately better prepared to provide such care. Thus the experiences are perceived as rewarding, regardless of the strain on the nurses' emotional resources. To the Israeli nurses, the tasks associated with post-mortem care are new. Not only are the tasks not considered, by the nurses, to be within the realm of nursing care, post-mortem care was taught "hands on." Socialisation into the task was short. The rationale for the care was not fully internalised and accepted. Future studies should assess the impact of training and socialisation on levels of comfort with post-mortem care and death. Such investigations would provide valuable information on which to base education, training and supervision, as well as advance knowledge of the complexities of attitudes toward death and level of comfort with tasks associated with post-mortem care.

Thirdly, in the past two decades, knowledge and literature about death and dying has proliferated rapidly. However, literature concerning attitudes toward death and dying among different cultural and ethnic groups is scarce. Canada is a cultural mosaic, and ethnicity and diversity are the quintessence of Canada's uniqueness. Nurses are not an homogeneous group. The heterogeneity of the larger society is reflected and reproduced among nurses. Hence, it is imperative that we understand the role which culture and ethnicity plays, and the influence it exerts in forming individual attitudes and perceptions about life and death. Research is needed, not only to contribute to our understanding of

nurses' perceptions of the phenomenon of death, but more importantly, to improve nurses' level of comfort with the complexity of care when confronted with life and death, the dying and the living.

APPENDIX A

QUESTIONNAIRE

1. **How long have you been a nurse?**

____ less than a year
____ 1 - 5 years
____ 6 - 10 years
____ 11 - 15 years
____ 16 - 20 years
____ 21 years and over

2. **What is your age?**
____ under 25
____ 26 - 30
____ 31 - 35
____ 36 - 40
____ 41 - 45
____ 46 - 50
____ 50 and over

3. **What is your sex?**
____ female
____ male

4. **What is your present marital status?**
____ single
____ married
____ separated
____ divorced
____ widowed

5. **What is the highest level of education you have attained?**
____ R.N. Diploma
____ Baccalaureate Degree
____ Master's Degree
____ Doctorate

6. **How long have you worked in this unit?**
____ less than a year
____ 1 - 3 year
____ 4 - 6 years
____ 7 - 10 years
____ 11 - 13 years
____ 14 years and over

7. **Prior to your nursing training had you ever seen a dead body?**
   ____ yes
   ____ no

8. **Prior to your training, had you ever touched a dead body?**
   ____ yes
   ____ no

9. **When you started your nursing career, how much did you fear touching a dead body?**
   ____ not at all
   ____ a little
   ____ somewhat
   ____ much
   ____ very much

10. **If yes, what did you fear? (If you require additional space, please write on the back of the page.)**

11. **What other reservations did you have about handling a dead body? (check all that apply)**
   ____ no reservations
   ____ aversion
   ____ repulsion
   ____ distaste
   ____ anxiety
   ____ uneasiness
   ____ disgust
   ____ loathing
   ____ other, please specify _____

12. **Prior to your transfer to this unit how many times did you provide post-mortem care?**
   ____ once per month
   ____ 2 - 3 times per month
   ____ 4 times per month

____ 2 - 4 times per week
____ 4 or more times per week

13. **Since your transfer to this unit how many times did you provide post-mortem care?**
____ once per month
____ 2 - 3 times per month
____ 4 times per month
____ 2 - 4 times per week
____ 4 or more times per week

14. **Do you remember the first deceased patient you provided post-mortem care to?**
____ yes
____ no

15. **If yes, please describe what made the experience memorable. (If you require more space, please write on the back of the page)**

16. **Do you have any other post-mortem care experience that left a memorable impression?**
____ yes
____ no

17. **If yes, please describe the experience. (If you require more space, please write on the back of the page.)**

18. **Describe what you feel when caring for a recently deceased patient. (If you require additional space , please write on the back of the page.)**

19. Are there situations when you find it difficult to provide post-mortem care?

____ yes
____ no

20. If yes, describe what makes the experience emotionally difficult. (If you require additional space, please write on the back of the page .)

21. How do you deal with your feelings in these instances? (check all that apply)

____ formal support services in the unit
____ informal support in the unit i.e. co- workers
____ friends, family
____ religion
____ other, please specify _____

22. Have there been times when post-mortem care has been a positive or rewarding experience?

____ yes
____ no

23. If yes, please describe the experience. (If you require additional space, please write on the back of the page.)

24. Do you consider the body as a patient during post-mortem care?

____ yes
____ no

25. If yes, does it make the task easier?

____ yes
____ no

26. Do you find any aspect of post-mortem care unpleasant?

____ yes
____ no

27. If yes, please describe what aspect and what makes it unpleasant. (If you require additional space, please write on the back of the page.)

28. At any point during the wrapping is the patient transformed into "just a body " or an object?

____ yes
____ no

29. If yes, when does the patient become just a body? (If you require additional space, please write on the back of the page.)

30. Describe the post-mortem care procedure you follow. (If you require additional space, please write on the back of the page .)

31. Which part do you cover first and why? (If you require additional space, please write on the back of the page.)

32. Is the sight of a wrapped body upsetting to you?

____ yes
____ no

33. If yes, how upsetting is it to you?

____ not upsetting at all
____ slightly upsetting
____ moderately upsetting
____ very upsetting

34. For what reasons is it upsetting? (If you require additional space, please write on the back of the page.)

35. How do you feel wrapping a recently deceased patient in a plastic shroud?

36. If you could, would you delegate post-mortem care to someone else?

____ yes (please answer question 37 and skip question 38)
____ no (please skip question 37 and answer question 38)

37. If yes, why would you? (If you require additional space, please write on the back of the page.)

38. If no, why wouldn't you? (If you require additional space, please write on the back of the page.)

39. Have you ever experienced the presence of the patient's spirit or energy in the room at the time of death or thereafter?

____ yes
____ no

40. If yes, please describe your most memorable experience. (If you require additional space, please write on the back of the page.)

41. What does death mean to you? (If you require additional space, please write on the back of the page.)

42. How religious would you say you are:

____ not at all
____ slightly
____ moderately
____ very religious

43. How spiritual would you say you are:

____ not at all
____ slightly
____ moderately
____ very spiritual

Please explain what do you mean by spirituality:

44. How often do you attend religious services:

____ never
____ about once or twice a year
____ several times a year
____ about once a month
____ two to three times a month
____ nearly every week
____ every week
____ several times a week

45. What is your religious denomination:

____ Roman Catholic
____ Protestant
____ Jewish
____ Muslim
____ None
____ Other, please specify _____

46. Has your frequent exposure to death and post-mortem care influenced your beliefs?

____ yes
____ no

47. If yes, please describe in what way has it influenced your beliefs. (If you require additional space, please write on the back of the page.)

48. In your opinion, what has had an important influence in forming your present attitude toward death: (check all that apply)

____ religious beliefs
____ personal values
____ death education program in nursing school
____ reference material (books, journals)
____ seminars, conferences, workshops
____ caring for the terminally ill
____ death of a loved one
____ other, please specify _____
Please explain:

49. How stressful do you find your encounters with death:

____ not stressful at all
____ slightly stressful
____ moderately stressful
____ very stressful

Your experiences and comments are extremely valuable to this study. Any additional experiences you would like to share will be greatly appreciated. Please call (514) 938-0325 or write to: Rahel Eynan-Harvey, 1700 Dr. Penfield Ave., Apt. 37, Montreal, Quebec H3H-1B4.

Thank you for your co-operation.

APPENDIX B

COVER LETTER

Rahel Eynan - Harvey
700 Dr. Penfield Ave., Apt.37.
Montreal, Quebec . H3H-1B4

Oct. 26th,1994

Dear Nurses,

Nurses' reactions to the death of a patient and their handling of post-mortem care, as you may know, remains largely undisclosed and understudied. The literature describing nurses' experiences giving post-mortem care is scant. The purpose of this study is to examine nurses' reactions to post-mortem care and their attitudes toward death.

The questionnaire was developed as a research instrument for an M.A. thesis in Sociology, at Concordia University. R.V.H. staff was consulted, and this study meets with their approval and support.

Your experiences are extremely valuable, not only to this study and the development of subsequent studies, but most importantly to other nurses. It is important that you describe your experiences in as much detail as possible. In fact, the more details the better. The study seeks descriptions of your personal experiences. Thus there are no right or wrong answers.

You are assured complete confidentiality. The questionnaire has no identification marking and you are not required to identify yourself, thus providing you with complete anonymity. Please use the pre-addressed stamped envelope enclosed to return your questionnaire.

In the event that you experience any emotional distress stemming from the completion of this questionnaire, please note that support services are available to you in the unit.

The findings of this research will be made available to all participants through the unit's Head Nurse.

I would be most happy to answer any questions you might have. Please write or call. The telephone number is (514) 938-0325.

Your assistance with this difficult topic is greatly appreciated. Thank you for your participation and co-operation.

Sincerely,

Rahel Eynan-Harvey

APPENDIX C
RESULT OF TESTS OF SIGNIFICANCE FOR DEMOGRAPHIC DATA

DEMOGRAPHIC DATA

"GOODNESS OF FITNESS TEST"

		CHISQ.	DF	p<
GENDER				
	Israeli Nurses	5.4	1	0.05
	P.C.U. Nurses	5.54	1	0.05
	Medical Nurses	5.14	1	0.05
MARITAL STATUS				
	Israeli Nurses	N.S.		
	P.C.U. Nurses	10.18	4	0.05
	Medical Nurses	N.S.		
EDUCATION				
	Israeli Nurses	10	4	0.05
	P.C.U. Nurses	N.S.		
	Medical Nurses	12.54	4	0.05
EMPLOYMENT IN PRESENT UNIT				
	Israeli Nurses	N.S.		
	P.C.U. Nurses	N.S.		
	Medical Nurses	7.46	2	0.05

APPENDIX D

SHROUD KIT

APPENDIX E

RESULTS OF TEST FOR ATTITUDES BY STATUS AND CULTURE

ATTITUDES BY CULTURE AND UNIT OF SERVICE

		CHISQ.	DF	p<
SEEN A DEAD BODY				
	Israeli Nurses	5.4	1	0.05
	P.C.U. Nurses	N.S		
	Medical Nurses	N.S		
TOUCHED A DEAD BODY				
	Israeli Nurses	11.27	1	0
	P.C.U. Nurses	N.S.		
	Medical Nurses	N.S.		
COPING WITH EMOTIONAL DISTRESS				
	Israeli Nurses	15	4	0.01
	P.C.U. Nurses	N.S.		
	Medical Nurses	24.65	4	0
DELEGATE POST-MORTEM CARE				
	Israeli Nurses	8.06	1	0.01
	P.C.U. Nurses	N.S.		
	Medical Nurses	N.S.		
RELIGIOUS SERVICE ATTENDANCE				
	Israeli Nurses	32.7	1	0
	P.C.U. Nurses	N.S.		
	Medical Nurses	N.S.		
ENCOUNTER WITH DEATH AND BELIEFS				
	Israeli Nurses	7.5	1	0.01
	P.C.U. Nurses	N.S.		
	Medical Nurses	N.S.		
RESERVATIONS REGARDING THE BODY				
	Israeli Nurses	24.71	8	0
	P.C.U. Nurses	20	8	0.05
	Medical Nurses	N.S.		

PRESENCE OF SPIRIT				
	Israeli Nurses	N.S.		
	P.C.U. Nurses	5.44	1	0.05
	Medical Nurses	N.S.		
REMEMBERING FIRST POST-MORTEM CARE				
	Israeli Nurses	N.S.		
	P.C.U. Nurses	N.S.		
	Medical Nurses	4.5	1	0.05
POST-MORTEM AS REWARDING EXPERIENCE				
	Israeli Nurses	11.27	1	0
	P.C.U. Nurses	N.S.		
	Medical Nurses	N.S.		

BIVARIATE CORRELATIONS

	CHISQ.	DF	p<	CC	Cramer's V
UNIT OF SERVICE AND PERCEPTION POST OF MORTEM CARE AS A REWARDING EXPERIENCE	13.35	2	0.01	0.53	0.65
UNIT OF SERVICE AND INFLUENCE ON BELIEFS	6.92	2	0.05	0.42	0.46
STRESS AND YEARS OF EXPERIENCE	N.S			0.49	
SIGHT OF THE WRAPPED BODY AND UNIT OF SERVICE	N.S				0.22

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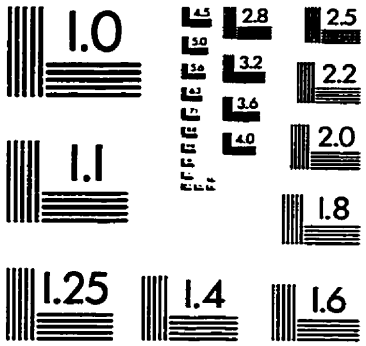

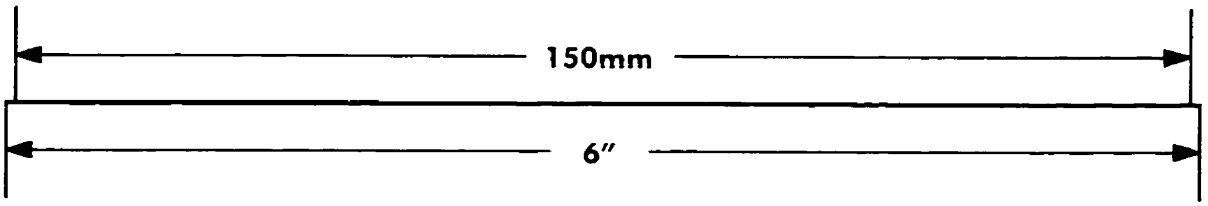

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